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October 21, 2011

The Honorable Timothy Geithner
Secretary
U.S. Department of the Treasury
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, D.C. 20224

The Honorable Hilda Solis
Secretary
U.S. Department of Labor
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
200 Constitution Avenue NW
Washington, DC 20210

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

ATTENTION: (Treasury), RIN 1210-AB52 (Labor) and CMS-9982-P (HHS)

RE: Notice of Proposed Rulemaking: Summary of Benefits and Coverage and the Uniform Glossary (76 Fed. Reg. 52442 [August 22, 2011]).

Dear Secretaries Geithner, Solis and Sebelius:

WellPoint Inc. (WellPoint) appreciates the opportunity to respond to the Notice of Proposed Rulemaking (NPRM) of the Summary of Benefits and Coverage (SBC) and the Uniform Glossary (Glossary), published in the Federal Register on August 22, 2011. We share the goal of ensuring that consumers receive clear and understandable information about their health

insurance or health plan coverage. WellPoint looks forward to working with the Departments of Health and Human Services, Labor and Treasury (collectively, “the Departments”) to craft a regulation that provides consumers with the information they need about their health plans while minimizing, to the extent possible, administrative burden on health issuers and health plan sponsors.

WellPoint is the largest publicly traded commercial health benefits company in terms of medical membership in the United States with 34.2 million medical members as of December 31, 2010, including both fully-insured and administrative service only (ASO) customers. WellPoint is an independent licensee of the Blue Cross Blue Shield Association and serves its members as the Blue Cross licensee for California; the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as Blue Cross Blue Shield in 10 New York City metropolitan counties and as Blue Cross or Blue Cross Blue Shield in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.), and Wisconsin; and UniCare Life and Health nationwide.

Background and Introduction

Section 2715 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act (ACA), requires health insurance issuers and plan sponsors to provide a summary of benefits and coverage no later than March 23, 2012. To facilitate this provision, the law also required the Department of Health and Human Services (HHS) to develop standards implementing Section 2715 no later than March 23, 2011. HHS did not meet this deadline for setting the standards.

Nevertheless, as proposed in the NPRM, the Departments would require health insurance issuers and group health plans to strictly meet a statutory compliance deadline of March 23, 2012, despite the fact that a Final Rule has yet to be issued.¹ Under such a truncated timeframe adequate compliance will likely be impossible to achieve, and the products health insurance issuers attempt to generate in an attempt to comply will likely be of poor quality and content, and will potentially confuse consumers and result in member abrasion. Just as HHS did not achieve the statutory deadline governing the issuance of the standards in this NPRM, it can and should correspondingly relax the statutory deadline imposed on the entities that are expected to comply with the regulations.

The NAIC workgroup that developed the SBC and Glossary templates did painstaking work over the course of many months. Industry members of the NAIC statutory workgroup did their best to explain why production of the SBC and coverage examples will create a significant regulatory burden for issuers. Representatives of the Departments participated in many of the NAIC’s teleconferences where concerns and issues were raised. However, the NPRM neither acknowledges these concerns nor accurately reflects the administrative burden and costs associated with producing and distributing the SBC.

¹ Because the Departments must review, evaluate and address stakeholder comments after the close of this comment period, it is possible that the Final Rule may not be issued by year-end 2011, giving regulated entities a scant 3 months or less to comply, which realistically cannot be achieved.

This NPRM raises a myriad of issues, challenges, and concerns, but we focus our comments on the critically important issues for consideration by the Departments. The issues that we believe are essential for the Departments to address are the following:

1. Too-short compliance date;
2. Administrative cost and burden, particularly with respect to furnishing the SBC to “shoppers” and the narrow standards for providing electronic delivery;
3. Inflexibility of template forms;
4. Insertion of premium figures in the SBC;
5. Exclusion of the large group market;
6. Coverage Examples;
7. Notice of Material Modification;
8. Interplay or conflict with state law requirements;
9. Requirement to distribute the SBC to beneficiaries living at a different address;
10. Dual duty on issuer and plan sponsor to distribute SBC;
11. Seven (7) day distribution period for the SBC;
12. Distribution of the Glossary; and
13. Conflicts between the NPRM and the template instructions developed by the NAIC.

Issue # 1: The NPRM requires a compliance date of March 23, 2012.

Recommendation: We recommend that the Departments provide health insurance issuers and health plan sponsors 18 months to comply after the Final Rule is promulgated, for plan or policy years beginning on or after the compliance date. We recommend that the Departments immediately announce that the March 23, 2012 compliance date will be extended, prior to issuance of the Final Rule, to preserve plan and issuer resources that are currently being devoted to planning for compliance based on the NPRM requirements. We also recommend that the Departments phase in compliance, starting with the individual market, beginning no sooner than 12 months after the Final Rule is issued, and then with the small group market² 6 months later. (This 12 month period assumes that the Departments agree to omit the requirement to insert premium information in the SBC, as we request below.)

Simply put, the NPRM proposes a compliance timeframe that issuers and plans cannot meet. The proposed requirements will require significant operational and technological changes. Carriers will need to devote a great level of effort and expend significant administrative expenses to develop the detailed and complex processes necessary to implement this regulation. Carriers must develop an SBC system and repository that can be maintained and accessed by all affected lines of the business and their various selling channels as well as accessible by all customer-facing associates. This new SBC process must be integrated with all enrollment, plan change process and mandated communications when policy changes occur. In order to include the premium on the SBC, extensive technical solutions must be developed such as data and systems integration with many of our e-vendors that provide quotes and application processing via the

² By “small group market,” we use the definition in Section 2791(e)(4) of the Public Health Service Act, as amended by Section 1563(a)(16)(B) (i) and (ii) of the Affordable Care Act, under which the small group market is comprised of employers having between 1 and 100 employees.

web. In addition, technical solutions such as web services must be developed and implemented to be used by our e-vendors to satisfy the requirement of providing SBCs to consumers during their on-line shopping experience. None of these processes or systems likely exists at any carrier today, so they must be built as a new product. A prodigious amount of information technology resources and testing must also be expended to attain compliance with these requirements. In other words, the templates are far from an existing “plug-and-play” capability.

It is essential that issuers and plans be provided adequate time to create these new processes and systems, load data, and test production of the SBCs and related documents before rolling them out to their customers and enrollees. If the Departments impose insufficient compliance time, some regulated entities will not be able to produce any documents, and some will produce poor quality documents, resulting in consumer abrasion and confusion. The current unachievable compliance timeframe will reduce customer confidence in the entity providing them with their health plan benefits, and will result in numerous complaints to the issuer or health plan, the employer or other plan sponsor, and also likely to the Departments issuing the guidance.

We also suggest that the requirements be phased in, both by document and by line of business. We recommend that the Glossary be phased in first; carriers could post that on their websites for customers to refer to, and it could also be posted on the HHS Web Portal for shoppers to read. The Coverage Examples document could be generated next, and finally the highly variable SBC by line of business, with the individual market phasing in first, then small group, then large group (if not exempted, as we recommend below). This will provide time to identify "lessons learned" in the process and to tweak processes and systems for the next market segment. Specifically, we recommend that the individual market requirements be implemented no sooner than 12 months after issuance of the Final Rule and that small group requirements be implemented 6 months later. (Compliance after a 12 month delay, however, is achievable only if the Departments remove the requirement to insert premium information in the SBCs.)

The Departments should also consider the views of employers and other plan sponsors. Many, if not most, of these entities did not closely monitor the NAIC’s development of the SBC templates and related requirements. As a result, the proposed requirements in the NPRM are now taking the marketplace by surprise. Since the issuance of the NPRM our group customers have posed many questions to us, such as:

- What will be the likely costs of producing the SBC, so that we can budget for 2012?
- How can we work together in such a short timeframe to share the data necessary to produce the SBCs?
- How will the NPRM requirements apply to our carve-out benefits, such as mental health or pharmacy?
- Will SBCs need to be issued for plans with a March 1, 2012 renewal date, or for an April 1, 2012 renewal?
- How do the open enrollment materials fit in?
- What if a group renews coverage on March 1, then changes benefits a month later (as is sometimes common with small groups) – must SBCs be issued?

These and other questions remain unanswered by the NPRM. The Final Rule, additional agency guidance, and a period of time for adequate compliance are needed in order to permit all parties to discuss, determine, and execute their respective roles and responsibilities.

WellPoint has been closely following the development of the SBC templates and issues surrounding the implementation of the SBC, Glossary, Coverage Examples, and the notice of material modification. Based on our internal planning, we believe that carriers need 18 months from the time the Final Rule is issued to make all of the procedural and information systems changes necessary to implement these requirements. However, if the Departments do not believe that they have the legal authority to extend the statutory compliance date in the ACA, we recommend that they adopt a non-enforcement policy for 18 months after the Final Rule is promulgated, which will serve the same purpose of granting regulated entities time to plan, implement, and execute the needed changes.

Issue # 2a: The Departments have underestimated the administrative cost and burden of issuing the SBC, particularly to a group of individuals (“shoppers”) who are not required by the ACA to receive it.

Recommendations: To reduce the administrative expense and burden of producing the SBC, we recommend that the Final Rule specify that (a) plans are not required to provide the SBCs to “shoppers”; and (b) electronic delivery is the default option for delivering the SBCs. We further recommend that the Departments update their cost estimate information to better reflect the true administrative expense that issuers and plans will incur in issuing these documents, as reflected in the letter submitted by America’s Health Insurance Plans (AHIP).

We recommend that the Final Rule omit the requirement that plans provide the SBCs to shoppers. The ACA by its express terms does not require SBCs to be provided to shoppers; this requirement was added by the NAIC during its development of the template forms. However, the ACA created the Web Portal (www.healthcare.gov) to assist consumers shopping for coverage. Supplying shoppers with SBCs would obviate part of the reason for the Web Portal’s existence.

If the Final Rule requires issuers and plans to provide SBCs to shoppers, then during the shopping process consumers will likely be inundated with these documents if they are comparing multiple plans. For example, WellPoint estimates that it would have to provide a shopper in the individual market with 21 SBCs reflecting all available plan options, as compared to enrollees who will receive just one SBC, reflecting their own plan. Requiring issuers and plans to distribute SBCs to shoppers exponentially increases the cost and administrative burden in producing and distributing the SBCs, since the issuer or plan will have to provide the SBC twice to the same shopper – ultimately resulting in confusion for members.³

We recommend that the Departments deem issuers and plans to have satisfied the requirement to provide SBCs to shoppers through the provision of information to the Web Portal for those

³ The SBC would be provided once during the shopping experience, and again when the individual applies for coverage.

shopping for small group coverage, in addition to the current NPRM proposal for individual coverage shoppers. The Web Portal is currently expanding the data available about coverage options in order to provide consumers and small employers with SBCs and premium information for the plans they are considering. Using the Web Portal as a method to provide SBCs to shoppers makes efficient use of a new government tool and allows issuers to focus on distribution of the SBCs at the point of application and enrollment.

Issue # 2b: The NPRM's electronic delivery standards are too narrow and will lead to increased administrative cost and burden on plans.

Recommendation: We recommend that the standards set forth in 29 CFR §2590.715-2715(4)(ii), and in 45 CFR §147.200(4)(ii) and (iii)(B) of the NPRM be relaxed to give issuers and plan sponsors more latitude to deliver the SBC documents electronically, which will reduce cost and administrative burden. Specifically, we recommend that the standard for electronic distribution of the SBC by the issuer to the plan or its sponsor in 45 CFR §147.200(4)(i) should be applied to both electronic delivery of the SBC documents in the individual market as well as to enrollees in group health plans and fully-insured groups.

We believe that the Departments have greatly underestimated the cost of complying with this regulation. The complex and burdensome rules for electronic delivery will cause most SBCs to be produced in paper, which is not only costly but environmentally unfriendly. Moreover, the strict electronic delivery rules will serve to add to issuers' administrative expenses at a time when they are expected to reduce them due to imposition of the federal MLR requirement.

We are concerned that the rules in the NPRM for electronic delivery of SBCs are complex and burdensome, especially in the group market, and that they will result in the distribution of most SBCs in paper form. We believe, in the interest of reducing administrative costs and helping protect the environment by reducing paper waste, that electronic delivery of the SBCs should be the default method of delivering the SBC and related documents.

Since 2002, ERISA has contained a safe harbor for electronic distribution of plan documents by employee benefit plans. Apparently recognizing that the ERISA safe harbor may be outdated, earlier this year the Department of Labor issued a "Request for Information Regarding Electronic Disclosure by Employee Benefit Plans," soliciting stakeholder opinions on "whether, and possibly how, to expand or modify these standards taking into account current technology, best practices and the need to protect the rights and interests of participants and beneficiaries."⁴ Despite this, the electronic disclosure methodology in the NPRM for the group market is even more restrictive than the existing ERISA safe harbor, and will create additional obstacles for health issuers and plan sponsors seeking to take advantage of cost-effective, prompt, and environmentally-friendly disclosure of the SBC documents.

Issue #3: The template forms are too prescriptive to accommodate all types of plan design.

⁴76 Fed. Register 19285 (April 7, 2011).

Recommendation: We recommend that plans and issuers be given additional flexibility in the template forms necessary to accommodate different types of plans, and SBCs translated into different languages.

The template forms developed by the NAIC workgroup were apparently designed to reflect provisions contained in contemporary major medical plans. However, older plans will not easily fit into the form, nor will some of carriers' more custom plans which address specific needs in the marketplace. For example, some high deductible health plans (with HSAs) have embedded deductibles, meaning that two or more family members are subject to the individual deductible as well as a family deductible. This type of plan cannot be accurately reflected in the current inflexible templates.

The template forms do not include space to put additional clarifying language for the consumer, and thus what will be populated might be misleading or confusing. If there were additional flexibility in the form, then adding clarifying plan information or even the translation taglines⁵ required by the NPRM could be accommodated. We note that it will be impossible for plans to add the translation taglines without altering the template forms, and moreover, that translated content may not fit precisely into the prescribed format. The font size, strict adherence to the chart format, and the requirement that certain information must stay on one page are challenging directives. Our preference would be to allow us to flow information onto the form in a certain order without boxing the information.

Issue # 4: The template SBCs require issuers and plan sponsors to insert premium figures.

Recommendation: We recommend that the Final Rule either omit the requirement that premium information be included or else simply require that premium be included in the SBC in a general fashion. While our preference is to omit premium information altogether, if HHS requires its inclusion, we recommend that, in the individual market, the Final Rule approve brokers and e-vendors to insert the premium estimate on the SBCs.

The ACA imposes no legal requirement that the SBC include premium information. In practice an issuer cannot insert a group enrollee's precise premium information, since issuers do not collect or possess information on enrollee contribution levels. We recommend that, in the group market, premium information be omitted completely or, at most, the Final Rule mirror the template Group Instructions developed by the NAIC in referring group enrollees to their employers for information on their share of the premium amount.⁶ The instructions also obligate employers to provide an addendum that identifies the premiums for each coverage level for each plan. We recommend that these provisions in the Group Instructions be reflected in the Final Rule.

In the individual market, practical and operational challenges also abound. One problem is that if the consumer requests dental and vision insurance, the premium quote represents the cost of health, dental and vision coverage. Many health insurance issuers use brokers and e-vendors to assist in issuing premium quotes to individuals applying for coverage, who have their own rating

⁵ See the proposed requirements at 29 CFR §2590.715-2715(2)(ii)(5) and 45 CFR §147.200(v)(5).

⁶ 76 Fed. Register 52475, 52496 (August 22, 2011).

tools and ways of comparing benefits between carriers. Issuers have no way of accessing brokers' or e-vendors' selling methods or programs, and it would be resource consuming and costly to set up and maintain a web service between the carrier and all possible brokers or e-vendors. We recommend that the Final Rule recognize that issuers may provide the SBC to applicants through broker or e-vendor channels.

Issue # 5: The NPRM includes the large group market in the requirements.

Recommendation: We recommend that the Final Rule exempt the large group market (including both insured and self-funded plans) from the requirements.

We believe that the wealth of information that large employers (whether insured or self-funded) provide at open enrollment gives enrollees sufficient information such that large employers should be exempt from the SBC requirements. HHS has countered that the ACA does not provide for such an exemption, but in another context (rate review) it specifically exempted large group coverage despite there being no such statutory exemption in the ACA.⁷

Moreover, application of the SBC requirement to large groups has additional challenges, in that a significant number of such groups have carve-out benefits, such as mental health and pharmacy. A plan sponsor will need to expend considerable time, effort, and expense building technological interfaces and implementing processes between all benefit providers to produce one integrated SBC. The alternative – multiple SBCs for multiple carve-out plans – will only serve to confuse enrollees.

Finally, we must address the expectation in the NPRM that health insurance issuers (including those who act as third-party administrators in administering claims for self-funded plans) will contract with group health plans / plan sponsors to work out the details of SBC distribution. For a company with the size and scale of WellPoint, working out those details and then recontracting with customers is an enormous, expensive, and time-consuming undertaking. It surely cannot be completed in the short time available before March 23, 2012.

If the Departments decide not to exclude large groups from the Final Rule, we recommend that they consider an alternative: an 18 month non-enforcement period essentially suspending the Final Rule's requirements for large group, during which the Departments would solicit stakeholder information on the adequacy of information provided by issuers and employers to shoppers, applicants, and enrollees of large group coverage, with the aim of determining whether and how the Section 2715 requirements should apply to the large group market.

This alternative makes sense for a number of reasons. First, the NAIC's deliberations focused on the individual and small group insurance markets. Due to the press of time, they never had an opportunity to discuss how the SBC requirements and templates would fit the large group insurance market. Second, the NAIC did not and indeed could not, because of lack of jurisdiction, address issues specific to large group self-funded plans. We recommend that the

⁷ 76 Fed. Reg. 29964, 29966 (May 23, 2011). Compare Public Health Service Act Section 2794 (federal rate review process applies to "health insurance coverage") with 45 CFR §154.103 (federal rate review process applies only in individual and small group market).

Departments convene a fact-finding technical work group or at the very least issue a Request for Information before imposing potentially conflicting and/or duplicative and expensive requirements on the large group market.

Issue # 6: Implementing the Coverage Examples requirement will be administratively costly and complex.

Recommendation: We recommend that issuers and plans be allowed to use alternative methods of compliance with the Coverage Examples requirement, which may include use of a cost transparency tool containing information on provider costs for particular procedures. We further recommend, if the Departments decide to include shoppers in the Final Rule, that HHS post a calculator on the Web Portal permitting shoppers to calculate and view the costs for different scenarios of treatment for medical conditions under the different types of plans they are considering purchasing.

The Coverage Examples requirement, although well-intended, is cumbersome, will be expensive to implement, and, we believe, is less useful than tools already used in the marketplace. Many issuers have already developed cost transparency tools allowing their members to compare the cost and quality of providers for many different treatment scenarios. For example, WellPoint's Care Comparison transparency tool available to members would permit a member to determine the cost and quality of providers offering treatments for 59 different medical conditions in the member's location. Enhancements to this tool in early 2012 will also permit members to see what their out of pocket costs will be for a procedure performed by a provider in their location – for example, the normal delivery of a baby. Unlike the Coverage Examples proposed in the NPRM, which are based on the average cost of a procedure, issuer transparency tools are geographic-specific, providing a more customized cost estimate to a member. Imposing the prescriptive Coverage Examples content and format on issuers that have already developed these types of transparency tools requires them to expend more administrative costs on something that duplicates, and in some instances is not as comprehensive as, tools already available to their members.

We have previously recommended that the Departments omit the requirement that SBCs be provided to shoppers. However, if the Departments decline to follow that recommendation, then to satisfy the Coverage Examples requirement for shoppers, we recommend that HHS post a calculator on the Web Portal that will permit consumers shopping for coverage to insert different deductibles and coinsurance into the calculator to get an estimate of how the plan they are considering purchasing would provide benefits for a particular medical scenario. In this environment, HHS could limit the examples to six or expand them as it saw fit.

Issue # 7: The Notice of Material Modification does not fit the reality of the marketplace, where employers may make plan changes retroactively, or continue to make plan changes up to the time of renewal.

Recommendation: We recommend that the 60-day notice of material modification requirement be limited to situations where: (a) for individual or group insurance coverage, the issuer is making a change that restricts benefits and the change was not requested by the covered

individual or group; and (b) for group health plans, the plan is making a change that restricts benefits.

The NPRM requires that an issuer or group health plan provide 60 days' advance notice of a material modification to the plan. That requirement, however, does not take into consideration the needs of individuals or employer groups to make quick benefit changes based on their needs. It is not uncommon, for example, for individuals to request immediate changes to their individual policies. Under the NPRM, they could not have an immediate change, but would have to wait 60 days until the change became effective. Similarly, in a group health plan situation, if an employer wanted to impose a beneficial improvement to its employees' health coverage, it should be able to do so retroactively or immediately and not have to wait until 60 days after it sends a material modification notice. We do not believe the Departments should erect a regulatory barrier to the needs of individuals and groups to make quick benefit changes, particularly if the change enhances benefits or addresses a consumer's specific needs.

Thus, we recommend that the NPRM requirement be altered to state that 60 day advance notice of material modification must be provided for benefit changes that restrict benefits and, in the insured market, where the benefit change was not requested by the customer. We believe that consumers with individual health insurance coverage will be aware that they requested a change, and that usual issuer practice confirming that change would suffice to notify the consumer. We also believe that in the group insurance market, employers follow the ERISA rules on material modifications.

Issue # 8: Some states have requirements similar to the NPRM requirements and may impose different or conflicting requirements on health issuers' SBCs, leading to a multitude of SBCs with different content or format, which conflicts with the Congressional goal of having standard SBCs.

Recommendation: We recommend that HHS issue guidance simultaneously with the issuance of the Final Rule that provides state regulators and health issuers with clear guidelines as to what states' laws are applicable, and that in the absence of controlling law or regulation, the federal standard SBC cannot be altered by the state.

Both Public Health Service Act Section 2715(e) and the NPRM establish that the federal SBC standards will preempt any state laws that require a health insurance issuer to provide an SBC supplying less information than the federal SBC standards. While these provisions may appear clear on their faces, they are open to interpretation.

Several states currently have laws on the books that seem to impose stricter standards than the federal requirements under Section 2715. However, without federal guidance it is left up to each state regulator or even individual health issuers to interpret state laws to determine how they apply to the SBCs and what changes are required. There are many unanswered questions, such as: Are the provisions of those states' laws to be incorporated into the federal SBC, or will issuers be required to issue a state document along with the federal SBC? Moreover, if a state law is merely complementary to the federal requirements, may a state department of insurance require the federal SBC to be amended before use in that state? The issuance of multiple SBCs

to comply with conflicting or complementary state and federal laws will create customer confusion, which we believe is contrary to the intent of the SBC requirement.

Further, we are also concerned that state insurance regulators may require us to file the SBC with state departments of insurance, and may require changes and amendments to the standard federal SBC such that we have to maintain different state versions of the SBC for distribution. Alteration of the standard federal SBC format and content, absent any controlling state law specifically requiring such changes, will defeat the purpose of having a standard SBC and standard Glossary and will serve to increase costs and impose additional administrative burdens on health issuers.

Thus, we request that HHS issue guidance along with the Final Rule that provides all stakeholders with clarity on this issue. We realize that there is a delicate balance between state and federal powers but believe that this issue is important enough on which to seek clarity so that there is less confusion when the Final Rule is issued.

Issue # 9: The NPRM requires distribution of SBCs to beneficiaries who do not live at the same address as the participant / policyholder.

Recommendation: We recommend that the requirement to deliver an SBC to these beneficiaries be eliminated, and instead to make SBCs available on the Web for beneficiaries.

The NPRM would require health issuers to distribute SBCs to beneficiaries (dependents) who live at a different address than the enrollee. The ACA does not specifically require distribution of SBCs to beneficiaries, but rather just to applicants, enrollees, and policyholders/certificateholders. Health issuers do not currently collect or maintain dependent addresses, so establishing this requirement in the Final Rule would also serve to increase the industry's compliance and system modification costs. Thus, we recommend that health issuers be permitted to provide SBCs on their website for beneficiaries to access. We note that at least one sub-population of beneficiaries, dependent children up to the age of 26, are among those who are technology-savvy and would probably prefer having the SBC available electronically.

Issue # 10: The NPRM confusingly places the duty to distribute SBCs on both issuer and plan sponsor.

Recommendation: We recommend that the Departments provide clarity in the Final Rule regarding the specific obligations of issuer and plan.

The NPRM is confusing in that it requires the issuer AND the plan sponsor to distribute SBCs, such that it will not be clear who actually has the duty, and will likely cause abrasion between issuers and plan sponsors.

Issue # 11: In general, the NPRM requires delivery of SBCs within 7 calendar days of request.

Recommendation: We recommend that the Final Rule provide for at least 30 days for issuers and plans to provide the SBC, and that in the case of paper copies provided by mail, that the SBC be mailed within 30 days of the request.

The NPRM would require us to distribute SBCs upon request, within 7 calendar days. This requirement, which is not in the ACA, is too tight a timeframe and doesn't take into account weekends and holidays. We request that the 7 day period be expanded to provide health issuers with at least 30 days after a customer's request to mail hard copies of the SBC.

Issue # 12: The NPRM is confusing as to when the Glossary must be distributed.

Recommendation: We recommend that issuers and plans be permitted to make the Glossary available on their websites for applicants and enrollees.

The NPRM is unclear as to when the Glossary needs to be distributed. At one point the rule states that it is included in the SBC, but at other points the rule seems to indicate that the Glossary is a stand alone document to be distributed separately. The template forms, on the other hand, include a tagline at the bottom of the form pointing the consumer to the company's website for the Glossary. The Final Rule should clearly state that the Glossary should be made available upon an issuer's website rather than including it in the SBC.

Issue #13: There are numerous conflicts between the NPRM and the instructions.

Recommendation: We recommend that the Final Rule be amended to align with the instructions.

The NAIC workgroup developed instructions for health issuers to fill out the information in the SBC and coverage examples. However, there are several places where the instructions and regulation conflict, or where the instruction adds information to the SBC that the regulation does not require. The Final Rule should be amended to ensure that there is conformity between the instructions and the regulation text.

WellPoint appreciates this opportunity to offer our comments on how to ensure that health plan enrollees receive understandable information about their health plans. Should you have any questions or wish to discuss our comments further, please contact Judith Langer at (414) 459-6062 or Judith.A.Langer@WellPoint.com.

Sincerely,



Anthony Mader
Vice President, Public Policy