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Subject: **COMMENTS ON SBC PROPOSED RULES – PHS §2715**

First and foremost, the Secretaries need to SLOW DOWN and provide sufficient time for Plans and Insurers to have a reasonable opportunity to review over 150 pages of complex, detailed information. So many new rules are being issued at such a ridiculously fast pace, it is blocking any **reasonable opportunity** for much needed input from the people who have to comply with these rules.

"Group Health Plans" Definition – Clarification is needed: The proposed rules (page 7) define "group health plan" to include both insured and self-insured group health plans. There are two categories of plans, **Church Plans** and **Self-Funded non-federal governmental plans**, mentioned throughout the Notice of Proposed Rule Making with no explanation or clarification as to the requirements these plans are subject to. Specific clarification is needed to indicate what rules apply to Church and non-federal governmental plans and what rules they are exempted from, especially self-funded plans. Are state and local governmental plans still exempted from the disclosure requirements that apply to ERISA Plans? **The rules should leave absolutely no doubt as to what is applicable to these plans.** This should be addressed for each of the following.

- On page 41, it states, "The enforcement authority under these provisions applies to all nongovernmental plans, but the DOL does not enforce the requirements of part 7 of ERISA with respect to Church Plans."

- Your referenced web site at http://ccio.cms.gov provides the following statement with no further explanation. Obviously, the second paragraph demands an explanation of what these plans are and are not subject to, so why is no further information provided?

Self-Funded Non-Federal Governmental Plans

Prior to enactment of the Affordable Care Act, sponsors of self-funded, nonfederal governmental plans were permitted to elect to exempt those plans, or "opt out of," from certain provisions of the Public Health Service (PHS) Act. This election was authorized under section 2721(b)(2) of the PHS Act.

The Affordable Care Act made a number of changes, with the result that sponsors of self-funded, nonfederal governmental plans can no longer opt out of as many requirements of Title XXVII.

This section is intended to provide information about this opt out provision. **The information in this section will be of interest to state and local government employers that provide self-funded group health plan coverage to their employees, administrators of those group health plans, and employees and dependents who are enrolled, or may enroll, in those plans.**

SBC MANDATED FORMAT AS PROPOSED BY NAIC:

What is being proposed by the NAIC and by the SBC Proposed Rule Making pursuant to PHS § 2715 is **beyond belief** to anyone who works in the group health arena.

The Scenario section of the SBC is beyond ludicrous as it creates a hugely subjective format that totally defeats the stated purpose of providing an "objective comparison".

Treatment services vary WIDELY by provider and exact nature of the illness for any given patient. To have the Plan/Insurer input dates, CPT Codes, Provider Type and the Allowed amounts for the treatment for several sample illnesses is an estimate or conjecture at best and adds absolutely no value to the SBC whatsoever**. This proposed NAIC process needs to be abandoned and replaced by a reasonable, objective and uniform standard (dollar amount for specific services, # of visits, etc.)**.

It is totally unreasonable to expect non-medical staffs of Plans, insurance companies and TPA's to complete a list of theoretical services and charges to treat a "theoretical" illness in order to come up with estimated costs for comparison purposes. This creates vast leeway to report codes in such a way so as to give a plan more favorable results. There is no way each plan is going to use identical procedure codes, providers and services unless those codes are a part of the fixed criteria. You are, in essence, asking administrators to create a treatment plan that is tantamount to an *"unauthorized practice of medicine"*. A standard caveat should be added stating: *"The following examples are illustrative only based on utilizing Network Providers only. The actual charges will vary by location and place of service, type of provider; and services will vary based on the treatment plan and services provided for each specific situation. Your costs would be significantly higher if you use out of network providers."*

A much more realistic and accurate approach can be accomplished by following standardized examples similar to the ones provided below based on an actual plan. It is essential for equitable comparison to specify the number of visits, treatments, etc. in the examples—not permit plans to come up with their own!

Example 1: Having a Baby (normal delivery) – $10,000 total allowed charges

What you Pay: $15 Provided you Enroll in Pre-Natal Plan (Healthy Beginnings during lst 14 weeks of pregnancy.) **What Plan Pays: $9,985**

If you do not enroll in Healthy Beginnings during first 14 weeks of pregnancy:
You would pay: $350 for NHAI providers ($600 if other PPO providers used)
What Plan Pays: $9,650 for NHAI providers ($9,400 if other PPO providers used)

Initial Office Visit	$15 copay for NHAI providers or $20 for other PPO Providers.	$15
Subsequent Office Visits (8 in total)	Paid at 100%, if enrolled in Prenatal Program, Healthy Beginnings apply. $15 for NHAI providers and $20 for Other PPO Providers.	$0 if Enrolled in Pre-Natal Plan **$120** if Not Enrolled in Pre-Natal Plan, Office visit copays apply **($160 for other PPO providers.)**
Lab Tests (4 in total)	Plan covers at 100% for Healthy Beginnings enrollee, otherwise Office visit copays apply ($15 NHAI/$20 Other PPO providers)	$0 if Enrolled in Healthy Beginnings **$60** if Not Enrolled and NHAI Provider **($80 if other PPO Provider used)**
Hospital Charges for 2 days (mother)	Hospital paid at 100% if enrolled in Health Beginnings. Otherwise, hospital copay applies: $50 per day up to $250 for NHAI hospitals and $100 per day up to $500 for Other PPO hospitals.	$0 for Health Beginnings Enrollees or **$100** for NHAI Hospital **($200 for Other PPO Hospital)**
Anesthesia	Plan covers at 100% up to allowed charges for in or out of network providers. Member responsible for excess charges for out of network providers.	$0 for network provider or any excess charges for out of network provider.
Routine Baby Care (in hospital 2 days)	Plan covers at 100% if enrolled in Healthy Beginnings, routine nursery care paid under mother's claim. Otherwise covered under baby's own claim and subject to Hospital Copay of $50 per day up to $250 for NHAI providers and $500 up to for Other NHAI PPO Providers.	$100% if enrolled in Healthy Beginnings, or **$100** for NHAI Hospital or **$200** for Other PPO Hospital if you did not enroll in Healthy Beginnings during lst 14 weeks.
Circumcision	Paid at 100% if done following delivery. Otherwise subject to surgical copay of $50 for NHAI provider and $100 for Other PPO Providers.	$0
Vaccines & Well Baby Care	Paid at 100% if Preventative vaccine. Otherwise, office visit copay of $15 for NHAI and $20 for Other PPO providers.	$0 $15 for diagnostic office visits

Example 2: Treating Breast Cancer (in network) – $78,000 Total Allowed Charges

What you Pay for NHAI PPO Providers: $ 2,210 NHAI PPO Providers: $75,640
What Plan Pays for NHAI PPO Providers: $2,500 Other PPO Providers: $75,290

Office Visits (8 specialist and 3 primary care visits) – **Allowed charges = $1,470**	$15 copay for NHAI providers/$20 for other PPO Providers – **Allowed Charges $150 ea for Spec. and $90 for Primary Care.**	**$150** NHAI providers **$200** Other PPO Providers
Radiation /Chemo (6 treatment) @ **$5,500 per treatment** = **$33,000**	Paid at 100% (drug copays would apply – office visit copays are waived)	$0
Hospital (5 days) – 1 stay – **Allowed Charges are $18,000**	$50 per day up to $250 for NHAI hospitals and $100 per day up to $500 for Other PPO hospitals. The maximum limit on hospital copays is $1,000 in network. **Allowed Charges = $18,000**.	**$250** for NHAI hospital **$500** Other PPO hospital There is a $1,000 is maximum limit on PPO hospital copays
Surgery – 1 Inpatient - **Allowed Charges $7,450**	Surgery copay is $ 50 copay for NHAI Providers and $100 copay for Other PPO Provider – Facility Fee is paid at 100%	**$50** for NHAI surgeons **$100** for other PPO surgeons
Anesthesia – Allowed charges **$3,000**	Paid at 100% up to allowed charges. Member responsible for excess charges for out of network providers.	0
Lab (5 visits) – allowed charges **$900**	Lab tests are paid at 100%	$0
X-rays (4 visits) - Allowed Charges **$1250**	$15 for basic X-rays and $100 for complex x-ray or diagnostic tests costing $2,500 or more.	**$160**
Wig - **$500**	Paid at 100% up to $250	**$250**
Pharmacy (Retail)/Mail Order Copay is 2 times retail copay - **$12,430.**	Generic Drugs (30 days) - $5 copay Brand Drugs – $ 30 copay Specialty Drugs - $50 Copay Maximum limit on Rx Copays: $1,500	**$1,500** assumes maximum out of pocket for Rx would be met.
Total Estimated cost that you would pay: **PPO Deductible:** none **PPO Out of Pocket:** $1,000 (assume this would be met.) **Rx Out of Pocket**: $1,500 (assume this would be met.)		**$2,360 for NHAI providers** **$2,710 for Other PPO Providers**

Example #3: Managing Diabetes (in network) – $ 7,800 Total Allowed Charges

What you would pay: $1,400 ($1,440 for Other PPO Providers)
Plan Pays: $6,445 ($6,600 for other PPO Providers)

Primary Care Office Visits (4 primary care) **Allowed Charges = $280**	$15 copay for NHAI providers/$20 for other PPO Providers. Copay is the same for specialists and primary care providers.	**$60** for NHAI providers and **$80** for other PPO providers
Specialist Office Visits (1) **Allowed charges = $90**	Copay is the same for specialists and primary care providers.	**$15** for NHAI providers and **$20** for other PPO providers
Lab Tests (4 basic test visits) **$220 Allowed**	Paid at 100%	$0
Test Strips (90 per month) and supplies (needles, wipes) **Rx Cost = $1,200** **Need to break out supplies and insulin since some plans subject these to copays.**	Test strips, equipment and supplies are paid at 100% for diabetics enrolled in the Diabetic Program. If Medicare is primary, then supplies are to be covered under Medicare Part B first and NHAI is secondary.	$ 0 enrolled in diabetic program. Rx copays apply if not enrolled in Diabetic program.
Insulin – **Rx Cost = $1,300**	Paid at 100% for enrolled diabetics. Otherwise, normal Rx copay applies.	$0
Pharmacy – Rx Copay under Plan excluding insulin and test strips and supplies: **Cost of all other drugs: $4,710**	Plan Rx Copays: 30 days (90 days): Assumes 90 day refills under mandatory mail order on maintenance drugs. **Plan Rx Copays/Coinsurance:**	**Rx is meaningless unless the Example has a list of specific drugs to be covered or the # of scripts and cost for each category.**
Preferred Generic **(3 scripts)**	$5 for 30 days and $10 for 90 days	**$120**
Non Preferred Generic **(1 script)**	$5 copay for 30 days and $10 for 90 days or ingredient cost, if less.	**$40**
Preferred Brand **(1 script)**	$30 copay for 30 days and $60 for 90 days, or ingredient cost if less.	**$480**
Non Preferred Brand **(1 script)**	$30 copay for 30 days and $60 for 90 days or ingredient cost, if less.	**$240**
Specialty Drugs	$50 copay for 30 days and $100 copay for 90 days	**$400**

Total Drug Costs	**Is there a Maximum Out of Pocket limit on Rx copays?** Yes, $1,500	**$1,355**

"60-Day Notice" Requirements are Unrealistic and Unreasonable: Most insurers and stop loss carriers for self-funded plans do not provide renewal quotes within 60 days of a renewal date. Most states only require notice of renewal rates 30 days prior to the renewal date. Thus a plan sponsor has no idea of what the rate increases are going to be and they need sufficient time to compare rates and plans before making a final decision. Today, employers are often forced to change deductibles, out of pocket amounts and copays in order to be able to "afford" a group health plan.

- Some plans (like the Civil Service Plans) have open enrollment 2 months prior to the effective date in order to have sufficient time to process all the enrollment changes, e.g. Open enrollment is November with changes effective January 1.
- A minimum of 30 days is needed by Plan Sponsors to analyze their options.
- A minimum of 30 days, once a decision is reached is needed to prepare the necessary Notice of Material Modification and SBC's in order to distribute the necessary disclosures proposed by these rules.
- Insurers need a minimum of 30 days to request renewal information and to review claims information to date, which realistically would only cover the prior six months.
- Additional time is required for self funded plans since stop loss carriers do not have direct access to claims information as an insurance company does and they are much more demanding in terms of the information they require for a quote and all the claims, precertification, catastrophic claims and census information must be assembled and provided by the TPA on behalf of the Plan. **This means that renewal information needs to be provided to the insurer or stop loss carrier at least 5 months prior to the renewal date!**

Plan Sponsors have minimal control over this process and without certain mandates on insurers to provide renewal quotes a minimum of 120 days prior to the renewal date, Plans are placed in an impossible position.

What is "reasonable" and "realistic" is to:

1. Only require the SBC and/or Notice of Material Modification at the beginning of the Open Enrollment Period or 30 days prior to the renewal date, whichever is later. Many plans, due to time constraints do not have a full 30 days for open enrollment.
2. Permit Plan Sponsors the option of providing a Notice of Material Modification in lieu of an SBC at the beginning of the Open Enrollment Period which must begin no earlier than 60 days prior to the beginning of the Plan Year or renewal date. In the Small Plan Market, where employers are allowed minimal deviation, if any, in terms of Plan design, the insurer would have SBC's readily available. This is not the case for most self funded plans or plans that are in the middle to large case market.

Additional time is needed for such plans to update their SBC's. The revised SBC should be provided within 60 days of the beginning of the Plan Year provided a Notice of Material Changes was provided with the Open Enrollment Material. At present, both Plans and Employees rarely receive a copy of the Insurance Certificate or Policy until 30-90 days following the effective date. The primary communication of plan benefits is a brief summary of the benefits during open enrollment and/or a Notice of Material Modification or Change.

3. The current rule of providing information within 60 days of any change is much more realistic and reasonable. The 210 day rule for updating the SPD is probably not reasonable. However, as is pointed out in these proposed rules, the length of the SPD's today is 150 to 200 pages -- primarily due to excessive Federal disclosure rules. There are so many "Mandated Notice" requirements that it is almost impossible for a plan to determine if they are all adequately covered and yet the Secretaries continue to impose even MORE NOTICE requirements—both in SPD's and additional separate notices that are required annually, such as the Women's Health and Cancer Act and the Medicare Part D Notices. **SBC's should not be included in the SPD—the SPD already requires too much information to be disclosed. In conjunction with the SBC rules, clarification is needed as to the SPD rules and their applicability to Church and Local/State governmental plans.**

4. EMPLOYERS MORE THAN ANYTHING, NEED RELIEF FROM EXCESSIVE BURDENSOME REGULATIONS AND NOTICE REQUIREMENTS! If a notice is included in the SPD, that should suffice, along with a "brief" reference in the annual Notice of Material Modification to remind employees to refer to their SPD's. I would submit that a Notice of Material Modification should be required annually to advise employees, whether or not there has been any change in the Plans offered, the contribution rate for employees and to list "material changes" in benefits, copays, deductibles, out of pocket limits, type of plan or provider networks with SBC's (excluding premium rates) to be provided within 30 to 60 days following the beginning of the plan year or the effective date of change, whichever is earlier. Employee rates should not be included or required in the SBC since they almost always change annually. SPD's should only be required to be updated if there has been a material change in benefits within 90 to 180 days following the effective date of the most recent material change. Amendments to the SPD's versus total restatements should be limited to three amendments and then all amendments must be incorporated into a total restatement.

5. Final rules should clarify that the SBC is to be limited to 8 pages and it should follow the same format and order as provided; however, there should be no attempt to limit what items should appear on which page due to the different descriptions that may vary considerably in length from plan to plan.

The last thing that is needed is more attempts to micro manage every last detail. The font size, format and order of the information in the SBC is sufficient.

Summary of Benefits and Coverage (SBC) Distribution Requirements: The notice requirements and options are excessive. With today's technology and trends, including those exercised by the Federal Government, such as not mailing out 1040 packages and forcing tax forms to be filed electronically, etc., the distribution rules for notices to employees, including electronic distribution requirements, needs to be updated. Many employers provide a web site where plan information can be maintained. From a practical and cost standpoint, employers should be permitted to choose the form of distribution, including placing all required material on a web site which may also include links to the insurer's or TPA's web site.

1. Distribute an SBC with the INITIAL Open enrollment information (hard copy). For ongoing renewals, there should be no requirement to distribute SBC's except for new employees if the employer distributes hard copies of SBC's. This would not be required for employers or insurers utilizing online enrollment. There should be no requirement to distribute the SBC more than once during any Plan Year, other than as requested by the member.

2. SBC's should be a stand alone document and should not be included in the SPD's. There are already too many requirements of what must be included in the SPD's.

3. For plans that require online enrollment, the notice requirements would be met if there is a link to the SBC on the online application to enable the employee/retiree to view, print, or download the SBC file.

4. Always, any eligible employee or retiree would have the option of requesting either a hard copy or a copy via e-mail of the enrollment form and/or SBC as well as other Plan information at any time up to a maximum of 3 times during any calendar or Plan Year.

To require employers to allow employees to pick and choose among 3 different options (e-mail, online, or hard copy) creates additional administrative and tracking issues, especially if e-mail options include maintaining read receipts, etc. to comply with the burdensome electronic tracking rules. We need more accountability from employees. The employer should be required to include in the enrollment material, e.g. Notice of Material Modification, SPD, SBC, etc. where to access information or who to contact for a hard copy is included. Then the responsibility should be on the employee to access such information online or to request a hard copy.

Cost Estimates for Compliance: The Secretaries have indicated a desire to avoid duplication and reduce the burden by facilitating electronic transmittal of the SBC, where appropriate. Yet there is little evidence in this proposed rule making that the end result comes anywhere close to meeting the stated objective. For example:

1. The only obligation to provide insurance information should be to the employee or retiree. All coverage is based on the Primary Member's election (except for Qualified COBRA Beneficiaries); therefore, there should be absolutely NO requirement to mail anything to other addresses of record for covered spouses or dependents. The only

requirement should be to require plan information to be provided upon request to any covered beneficiary.

2. It is appropriate to require Plans to provide SBC's or other Plan information upon request, including advising the member where such information can be viewed, downloaded or printed online.

3. To reduce the administrative burden and cost, the Employer, TPA and or Insurer should be able to meet ALL notice and disclosure requirements for SBC's and Glossaries by posting such documents on a web site that is communicated to the employees along with the right of any covered member to request copies of such documents in writing by email or by mail. From a practical standpoint, employers must provide a notice of material modification annually and/or an updated SBC to notify employees of any changes or the fact that the plans are not changing except for the new employee premium rates.

The cost estimates are totally inadequate. The time and cost burdens "per plan" is significantly higher for TPA's and most self-funded plans. To estimate that each issue/TPA would need only 3 hours to produce and 1 hour to review, SBC's for all products is ludicrous—especially considering the Scenarios requirements as currently proposed. Seriously, when you have 132 pages of proposed rule making plus 15 pages of instructions on how to complete the Mandated, Standardized SBC format, it could easily take 8 to 10 hours to prepare an SBC for a self funded plan PROVIDED the current SCENARIO page is eliminated!. You failed to address the fact that a significant number of large plans are not boiler plate plans, like many fully insured plans with standardized language. Customized plans will take longer. You also failed to consider the COST of updates. Given the current regulatory environment, plans are forced to make changes—often several times a year in the current environment of excessive regulations; therefore one-time expenses are not accurate or realistic.

The estimated cost of each paper notice being $ .49 including $ .44 for mailing, is also grossly understated as you have ignored the most costly component being the people cost. Someone has to prepare the notices for mailing, etc. Further, most mailings would result in higher postage costs than $ .44 per mailing, especially if enrollment forms, glossaries, or additional information is included with the SBC. Actual costs are more likely to be more than at least triple and quadruple these estimates.

Private sector input is being ignored. There is inadequate representation from the business world in order to take into account every day realities into the process. There is too big of a RUSH to produce voluminous rules with inadequate time for analysis and comment, which appears to be designed to be able to greatly restrict and ignore public comment. This process is reprehensible and is the reason for the public outcry for relief!