October 21, 2011

Office of the Health Plan Standards and Compliance Assistant
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

RE: Comments on Summary of Benefits and Coverage & Uniform Glossary Requirements Proposed Rules – PHSA §2715

Dear Sir or Madam,

The requirements of PPACA are putting a considerable strain on the benefits industry and the current March 23, 2012 deadline for group health plans to provide a uniform Summary of Benefits and Coverage is fast approaching. With many of the key issues remaining unresolved, we request a delay in the effective date of at least one year. Additionally, we ask to be able to phase in these summaries at each group's annual renewal. Furthermore, we ask that the agencies re-evaluate the mandated length of the SBC and request that the 60-day notice requirement be shortened. Below are some of the key issues that remain outstanding as well as information to support the validity of our requests:

1. The proposed SBC template was created from the fully-insured point of view despite the fact that the vast majority of US health plans are self-funded. The error is understandable since NAIC works with state insurance departments in their management of the fully-insured health marketplace, so its approach envisioned fully-insured plans without consideration of their self-funded counterparts. Under ERISA's preemption provisions, state insurance departments generally do not have authority over self-funded welfare benefit plans.

2. The terminology used in self-funded plans typically does not correspond with that used by insurance carriers in their fully-insured policies of insurance. As such, terms could lead to confusion of participants and beneficiaries.

3. The template is not user-friendly for the self-funded plan sponsor or for third party administrators that will ultimately be managing this process for their employer clients. Using the template in the suggested version from the NAIC, with persons who will be covered by a self-funded program, could lead plan participants to believe that the program they are looking at is a fully-insured program which it would not be. Providing a self-funded version of the SBC will help dissuade them of such a belief. Keeping this clarification has been a priority of NAIC for years, so proceeding with the template would be a step backwards.

4. A lot of time will be required by employers or their third party administrator to create these SBCs. Self-funded plans have the flexibility to provide customized features. They are not the standard plans used by many insurance carriers. Each summary will have to be individually crafted at a significant expense to the self-funded employer. If an employer has an indemnity plan, PPO plan, and a High Deductible HSA compatible plan, with 4 tiers of coverage each (single, single and spouse, single and children, and family) the number of separate Summaries multiplies quickly.

5. The arbitrary length of the SBC that was decided on will put strain on certain self-funded employers that have more creative benefit packages in order to keep costs lower. For example, a Hospital group may offer domestic facility benefits that are more generous than traditional in-network and out-of-network benefits in order to steer participants to use that domestic facility and keep plan expenses to a minimum. This is one example of many, and with the constraints of the proposed template, it is not feasible that these types of scenarios can all be accounted for. One of the most compelling reasons that an employer decides to sponsor a self-funded plan is the flexibility to create their own plan design rather than simply accept the standard-issue fully-insured policy. That flexibility is paramount in being able to provide essential coverage to the employee while keeping expenses low. This works to the benefit of both the employer and the employee since this prudence also keeps employee premiums affordable.

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6. The 60-day notice requirement is not realistic. From a real-world perspective, most stop-loss carriers do not provide renewal quotes outside of the 60 days prior to the renewal date so that they can gather as much information about the plan's performance during the plan year as possible in order to determine rate changes. Since rate changes from the stop-loss carriers have a direct affect on employee premiums, deductible and coinsurance amounts, out-of-pocket amounts and the like, a plan administrator will need this information prior to making renewal changes to the plan. Just as the intent of the law is to provide employees with enough plan information to make an informed decision, the same consideration should be extended to plan sponsors. If plan sponsors do not know what their rate increase will be and will not be given sufficient time to compare rates and plans before making a final decision about an potential increase in plan expenses, it could prove to be detrimental to plan costs. A much more realistic approach is to require the SBC be provided during the open enrollment period.

We thank you for your consideration to give us the time and opportunity to improve compliance with the changes that fit self-funded benefit plans and we look forward to a positive response to our suggestions.

Sincerely,

deCha Sanson
Contracts & Compliance Supervisor