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October 21, 2011

U.S. Department of Labor
Submitted via email at *E-OHPSCA2715.EBSA@dol.gov*

Comments on the *Proposed Rule on Summary of Benefits and Coverage and the Uniform Glossary* and *Summary of Benefits and Coverage and Uniform Glossary—Templates, Instructions, and Related Materials Under the Public Health Service Act*

RE: RIN 1210-AB52

To Whom It May Concern,

United Actuarial Services, Inc. (UAS) submits these comments to the *Proposed Rule on Summary of Benefits and Coverage and the Uniform Glossary* (*Proposed Rule*), published in the Federal register (76 FR 52442) by the Departments of Labor (DOL), Treasury and Health and Human Services (the Departments) on August 22, 2011, to implement a new section of the Public Health Service Act (PHSA) (Section 2715) created by the *Patient Protection and Affordable Care Act* (the *Affordable Care Act*). These comments also address the *Summary of Benefits and Coverage and Uniform Glossary—Templates, Instructions, and Related Materials Under the Public Health Service Act (Proposed Templates)* published in the Federal Register (76 FR 52475) by the Departments on August 22, 2011.

United Actuarial Services, Inc. (UAS) provides actuarial and consulting services to multiemployer group health care and pension plans and has been in business since 1951. We have clients in 27 states and are familiar with the special challenges of Taft-Hartley multiemployer plans and the collective bargaining process.

Multiemployer health plans provide health care coverage to millions of workers, retirees, and their families. Most multiemployer health plans are self-insured. The *Proposed Rule and Template* should recognize the unique differences between multiemployer self-insured plans that cover this large segment of the population and the single-employer insured plans the *Proposed Rule* and *Proposed Templates* were aimed at.

In reviewing the *Proposed Rule* and *Proposed Templates*, our focus was to identify the changes that need to be made to the *Proposed Rule and Templates* for multiemployer group health plans, in particular self-insured plans. Such plans do not fit the "insured plan" mold for which the *Proposed Rules and Templates* were drafted, which is no surprise given that the template Summary of Benefits and Coverage (SBC) and the Uniform Glossary were drafted by the National Association of Insurance Commissioners (NAIC) for use by health insurance issuers.

As such, the models do not reflect the design and operations of self-insured plans in general or multiemployer plans in particular. Significant changes in the template, the accompanying instructions, and glossary are needed to reflect the structure and operation of these plans. In addition, significant changes are needed in the *Proposed Rule's* approach to distribution of the SBC to ensure that distribution is coordinated with other required materials.

The National Coordinating Committee for Multiemployer Plans (the NCCMP) has submitted comments on the unique nature and structure of multiemployer health plans and we echo those comments.

The First Order of Business – Delayed Implementation

In particular, we join the chorus of employers and benefit professionals who believe the first order of business is a delayed implementation date. We agree with the NCCMP that the Departments should immediately announce a delayed effective date for plan sponsors to distribute the SBC until the first plan year that begins 12 months after the effective date of the final rule.

The *Proposed Rule and Templates* were published six months later than anticipated by the ACA. This pushes back the date for the analysis of comments by the Departments which in turn pushes back the publication of a *Final Rule and Template*. Thus, health plans, insurers and employers and left with little or no time to begin a task more time-consuming than estimated in the *Proposed Rules* analysis.

The Departments should announce a delayed effective date immediately. Individuals have survived for nearly 40 years with a Summary Plan Description and Summaries of Material Modifications. Taking another 12 months after the *Final Rule* is published will not prejudice consumers but merely allow sufficient time to properly implement this new requirement.

Adapting the SBC for Self-Insured Multiemployer Health Plans

There are significant differences between the coverage terminology applicable to insured plans and self-insured plans, especially multiemployer self-insured plans. These linguistic differences should be reflected in separate instructions and templates for such plans. While the language differences are significant, the different terms are often used to describe similar concepts.

For example, an insured plan refers to the coverage period as the "policy period" whereas a self-insured multiemployer plan would use the term "plan year." The differences are significant enough that they are worthy of clarification for the purpose of clear communication. Similar changes are also needed to the SBC *Proposed Template and Instructions*, including the following major changes:

- Language referring to a "policy" is not relevant. Self-insured multiemployer health plans by definition do not have an insurance policy. They have a plan

document that is the functional equivalent of a policy but reflects the unique non-profit nature and organization of self-insured multiemployer health plans.

- Similarly, references to insurance company websites are inappropriate. Reference to Plan websites or "Fund" websites would be appropriate.

- Terminology reflecting multiemployer health plan administration should be used such as "plan administrator", "Board of Trustees", "Fund Office" etc., and replace insurance-oriented terms. The Instructions are aimed at insurers and employers, entities which really have no similar role in self-funded multiemployer health plans. These revisions extend to the SBC headers where the insurers name and information is to be placed. The Plan name and type of coverage would be more relevant, such as the XYZ Plan – Actives.

- The concept of the term "premium" has no relevance for active (working) participants in self-insured multiemployer plans. As the NCCMP noted, self-insured plans do not charge a "premium," and multiemployer plans often require no employee contribution directly from the plan's participants as such costs are typically derived from an allocation of the negotiated wage package. For a self-insured plan, the proper question would be "What is the participant/employee's contribution?" However, on closer examination, it appears that multiemployer plans should not be required to provide premium or cost of coverage information in the SBC.

- As noted, multiemployer plans generally do not charge active participants any contribution amount to purchase plan coverage. Consequently, premium information would not be relevant to a participant in a multiemployer plan. The plan receives contributions based on work performed, but these contributions are measured based on hours worked or some other measurement of work, not on a health insurance premium. Consequently, there is no relevant figure that would be a "premium" for a multiemployer plan. This fact was implicitly acknowledged in the context of the W-2 reporting requirements, which, for the time being, exempt employers contributing to multiemployer plans. We recommend that the premium reporting requirement be removed but that, if it remains, it not apply with respect to coverage provided under a multiemployer plan.

    - Regarding retired participants in a multiemployer plan, there are premiums required. In most Plans, however, not all retirees pay the same premium. It is very common to subsidize based on years of service or retirement date. By requiring a premium to be included in the SBC would mean that each SBC would have to be personalized for each retiree.

    - Another confusing issue is what happens in those situations where members of the same family do not have the same benefits. For

example, in a two person retired family one of the retirees could be eligible for Medicare and the other not. It is common for multiemployer plans to supplement Medicare for those eligible for Medicare but to provide a reduced version of the active coverage for the non-Medicare eligible retiree. Would the regulations require two separate SBCs be provided to families in those situations?

- The "Your Rights to Continue Coverage" section on the Proposed Template does not reflect continuation coverage in the context of multiemployer self-insured ERISA plans. It does not mention the right to continuation coverage under COBRA or USERRA. If this section is required, an SBC that describes a self-insured plan should briefly describe those rights, and refer the participants and beneficiaries to the relevant provisions in the Plan document and/or SPD for a full explanation of their rights to continuation coverage under COBRA or USERRA.

- The "Grievance and Appeals Rights" section is misleading for multiemployer, self-insured plans. PHSA Section 2715 does not require that grievance, claims and appeals rights be addressed in the SBC. Self-insured multiemployer health plans are subject to the ERISA claims procedures, as modified by the ACA. This section should be eliminated or at least revised to refer participants and beneficiaries to the relevant provisions in the Plan document and/or SPD for a complete explanation of their claims and appeals rights under ERISA.

- The SBC does not have sufficient space for plans that have complex benefit structures. For example, some multiemployer plans have 4 tiers of prescription drug coverage and 3 subtiers under each tier. As you can see from the example below, there is simply not enough space to include this benefit in the template. The problem is even greater for plans that also have complex vision and dental care coverage. Some plans also have various levels of deductibles and other limits. Plans that have all of these complexities just do not have enough room in the allotted space.

  Multiple Tier Prescription Example:

  - A plan covers generic prescriptions purchased at a retail pharmacy where the participant pays a 20% co-pay with a $10 minimum and $20 maximum; or via mail order at a 15% co-pay with a $25 minimum and $50 maximum.

  - A plan covers preferred brand name prescriptions purchased at a retail pharmacy where the participant pays a 30% co-pay with a $20 minimum and $40 maximum; or via mail order at a 25% co-pay with a $50 minimum and $100 maximum.

  - A plan covers non-preferred brand name prescriptions purchased at a retail pharmacy where the participant pays a 40% co-pay with a $40

minimum and $80 maximum; or via mail order at a 35% co-pay with a $100 minimum and $200 maximum.

- A plan covers specialty prescriptions purchased at a retail pharmacy where the participant pays a 15% co-pay with a $8 minimum and $16 maximum for generics; a 25% co-pay with a $16 minimum and $33 maximum for preferred brand; or a 35% co-pay with a $40 minimum and $80 maximum for non-preferred brand.

Closing Comments

As noted, the NCCMP has provided an excellent description of multiemployer health plans and we will not parrot that here. The NCCMP also addresses other aspects of the *Proposed Rules and Templates* with which we agree. UAS is submitting these comments based upon its experiences in attempting to draft an SBC based on the *Proposed Templates.* We would suggest providing separate *Templates and Instructions* for insured plans and self-insured plans, with a section on multiemployer plan peculiarities.

Sincerely,

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