VIA E-MAIL (E-OHPSCA2715.EBSA@dol.gov)

Office of Health Plan Standards and Compliance Assistance
Employee Benefit Security Administration, Room N-5653
U. S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

***Att'n*: RIN 1210-AB52**

Ladies/Gentlemen:

The Mercer Outsourcing business ("Mercer") is pleased to respond to the request of the Departments of Treasury, Labor, and Health and Human Services for comments on the summary of benefits and coverage ("SBC") requirements of the Patient Protection and Affordable Care Act. These comments and recommendations address the proposed regulations issued under section 2715 of the Public Health Service Act and the contemporaneously proposed SBC template and instructions.

The Mercer Outsourcing business is an employee benefit plan record-keeping and plan administration services provider for defined contribution, defined benefit, health and welfare, absence management and related programs of many large and mid-sized employers. In addition to providing group heath plans with state-of-the-art enrollment and disenrollment and related services, Mercer's services include the design and production of participant communications, including world-class written and electronic materials that enable employees and their families to select health plan coverage, access a vast array of online health and wellness information, and otherwise optimize their health and their health coverage choices.

We find that a number of the features of the proposed SBC regulations and template would make it far more difficult to offer superb group health plan benefit information and decision-making to employees. In the following comments and recommendations, Mercer addresses some of the elements of the proposed regulations that seem especially counterproductive or unworkable, requesting their revision in final regulations.

1. On the Number and Types of SBCs to Be Provided

Section 2590.715-2715(a)(1)(ii)(B) and corresponding provisions of the proposed regulations require that a group health plan "must provide an SBC to a participant or beneficiary … with respect to each benefit package offered by the plan … for which the

participant or beneficiary is eligible." The definition of "benefit package" and, therefore, the number and types of SBCs that must be provided under this general rule, remain unclear.

Providing all SBCs to all individuals. We respectfully request that the final regulations provide that the SBC requirements will be met if a group health plan provides each participant and beneficiary with the SBCs for *all benefit packages* for which he or she is *or may become* eligible under the circumstances, along with notice that the participant or beneficiary should consult the group health plan summary plan description (SPD) and other disclosure documents or communications, to determine the benefit package(s) for which he or she is *or might become* eligible. For example:

> Employer W offers several group health coverage options – a national indemnity option, a national PPO option, and four geographically limited HMO options. Employee A does not live in any of the geographical locations covered by the HMOs offered by W. However, because of the possibility that Employee A may be considering moving to a state covered by one of the four HMOs, Employer W provides A and A's beneficiaries with the SBCs for *all six* of its coverage options, together with instructions to A to consult the SBCs and W's comprehensive health plan SPD to determine whether A is *or may become* eligible to participate.
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> Additionally, Employer W's employee, B requests in the middle of the plan year the SBCs for all benefit packages for which he is eligible. Because B is not then entitled to enroll or change coverage at mid-year, and because determinations of eligibility are customarily made by the plan only when an individual is entitled to enroll, it is unknown at the time of the request for what benefit packages B is eligible or will be eligible at the next enrollment opportunity (*e.g.*, the next open enrollment period or a HIPAA special enrollment event). W therefore provides B and B's beneficiaries with the SBCs for *all six* coverage options, together with instructions to consult the SBCs and W's health plan SPD to determine in which options they are *or might become* eligible to enroll

In short, we respectfully request that the final regulations provide that an employer group health plan will not fail to comply with the SBC requirements merely because it provides participants and beneficiaries with SBCs with respect to benefit packages *in addition to* those for which the individuals are eligible at the time of the request, together with instructions to consult the SBCs and other disclosure documents that have been provided, which enable the individuals to identify the benefit packages for which they are eligible.

Minimizing the number of SBCs. The proposed regulations do not clearly define what set of plan terms, benefits, premiums, etc. will constitute a discreet "benefit package." Depending on the breadth of the definition of "benefit package," the requirement that a plan sponsor "provide an SBC to a participant or beneficiary … with respect to each benefit package … for which [he or she] is eligible" may be excessively burdensome and/or defeating to participants and beneficiaries. We believe that the final regulations should define "benefit package" so that, in most cases, a typical benefit offering such as a

PPO, an HMO, an indemnity plan, etc. will constitute a single "benefit package." A more restrictive definition could lead to a confusing proliferation of SBCs in many common scenarios. In particular, the requirement of a separate SBC for each coverage tier (as indicated in the proposed instructions to the SBC templates and the "Sample Completed SBC" in Appendix B-1) rapidly multiplies the number of required SBCs, in some fairly ordinary situations. For example:

> Employer X offers three group health plan options – two PPOs and an HMO. To maximize cost savings for X employees, each such option provides for eight "coverage tiers" (employee-only coverage, plus seven other coverage tiers culminating in family coverage with five dependent children). X currently furnishes eligible employees with a professionally produced booklet describing the key features of the three benefit packages and concisely illustrating their application. Participants and beneficiaries also are given logon instructions to obtain information online, plus the toll-free telephone number of X's "benefits center" to obtain answers to specific questions. These information sources are in addition to the ERISA-required SPD for the plan. Under the proposed regulations, in addition to all of these existing resources, X's newly eligible employees would have to be furnished with at least 24 stand-alone SBCs.
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> Employer Y offers three group health plan options – two PPOs and an HMO. In addition to providing three coverage tiers, in order to maximize cost savings, each of these plan options provides for varying levels of premium, based upon factors such as participation in wellness programs, smoking-versus-nonsmoking, salary bands, and a special "spousal surcharge" on coverage for spouses who are eligible for another employer's coverage. Depending on the definition of "benefit package," the various combinations of coverage levels and other premium factors could lead to Y's having to prepare and provide each newly eligible employee with several dozen SBCs.

Thus, if a separate SBC is required for each coverage tier and for each other factor impacting premium costs, the number of SBCs provided to participants and beneficiaries will tend to be needlessly high. If, as the proposed regulations say, the SBC is meant to assist individuals in deciding which benefit package to choose and which family members to cover, requiring a separate SBC for each of the numerous permutations within each benefit package seems to add to confusion and, therefore, to be contrary to the intent of the law. Experience has shown that variations in costs, coverages and other factors can be described much more helpfully for participants and beneficiaries in the minimum number of documents, rather than by creating multiple separate documents for each option. Thus, we respectfully request that the final regulations clarify that, absent unusually significant benefit and cost variations within a benefit option (*i.e.*, within a PPO, an HMO, etc.), each of those benefit options requires only one SBC, and coverage tiers and other variables such as health factors, salary levels, surcharges, etc., may be disclosed where the cost information is set forth in that single SBC (for example, in the sort of SBC premium addendum suggested in the proposed regulations).

SBCs at open enrollment. Section 2590.715-2715(a)(1)(iii)(C) and corresponding provisions of the proposed regulations allow that, in the case of a renewal of coverage, "the plan …. is required to provide a new SBC automatically upon renewal only with respect to the benefit package in which a participant or beneficiary is enrolled …." We request that the final regulations provide that, if the benefit package in which the individual is currently enrolled is scheduled to be terminated and replaced in the next plan year, the SBC referred to may be the SBC for any benefit package into which participants and beneficiaries will be automatically "mapped" during open enrollment.

2. On the SBC Timing Requirements

March 23 effective date. The Mercer Outsourcing business has already devoted substantial resources of time and funding merely to begin to address the challenge of helping clients comply with the SBC proposed regulations – communicating with clients; assessing the complexity and cost of modifying administrative processes and computer systems; amending contracts; etc. We quickly concluded that the current effective date contained in the proposed regulations – enrollments and disenrollments on or after March 23, 2012 – would be impossible for employers to meet. The process of "sizing" and budgeting for the required changes, creating functional specifications, reprogramming data systems, modifying participant and employer communications, negotiating and executing service agreement amendments, etc., could take many months. Moreover, these tasks cannot be completed until final regulations are issued. Therefore, we respectfully request that the SBC requirements be made effective no sooner than the first day of the group health plan year beginning at least 12 months after the publication of final regulations.

Immediate eligibility for coverage and to enroll. Section 2590.715-2715(a)(1)(ii)(B) and corresponding provisions of the proposed regulations require that the SBC be provided to a participant or beneficiary "as part of any written application materials that are distributed … for enrollment" and that, if written materials are not provided, the SBC be provided "no later than the first date the participant is eligible to enroll …."

Many employers offer their employees immediate eligibility for health coverage and immediate eligibility to enroll, effective (often retroactively) as of the employee's date of hire. Many such employers also rely upon service providers like the Mercer Outsourcing business to calculate the benefit package(s) for which each new hire is eligible, prepare and furnish the appropriate enrollment materials, and process the enrollments, retroactive to the hire date. In such cases, access to electronic enrollment materials and enrollment process necessarily is provided *after the hire date – i.e.*, after "the first date the participant is eligible to enroll." Requiring delivery of the SBC "no later than the first date the participant is eligible to enroll" would require a delay in a new hire's ability to access existing educational materials and enroll in a benefit package. We respectfully request the proposed regulations include a clarification that, in the case of immediate eligibility to enroll, disclosure of the SBC will be considered timely if the SBC is provided electronically at the time access is provided to electronic enrollment materials

and the electronic enrollment process (as long as that date is within an administratively reasonable period after the employee's hire date).

We also respectfully request that the final regulations clarify that, in cases of immediate eligibility for electronic enrollment, an employee's consent to receipt of the SBC in electronic form, as a step in the electronic enrollment process, (1) will constitute valid consent under section 2590.715-2715(a)(4)(ii) and the corresponding provisions of the proposed regulations, which provide that "the SBC may be provided electronically if the requirements of 29 CFR 2520.104b-1 are met"; and (2) will satisfy the requirement contained in the proposed SBC instructions at 26 CFR Part 47, Appendix B-1, that an employee who conducts enrollment electronically must "acknowledge receipt of the [SBC] form as a necessary step to completing the enrollment application."

HIPAA special enrollees. Section 2590.715-2715(a)(1)(ii)(D) and corresponding provisions of the proposed regulations require that a plan "provide the SBC to [HIPAA] special enrollees … within seven days of a request for enrollment …."

In today's electronic enrollment environment, the initiation or modification of benefit elections typically is not a linear process whereby the employee requests enrollment information, reviews the information, and then enrolls. Rather, employees typically can log onto their regular benefits website, which offers comprehensive, interactive information on plan options, benefits and coverages (as well as access to a telephone call center at which answers to specific questions may be obtained). Once logged on, employees typically can effect the desired benefit change(s) – including HIPAA special enrollments – in a single Web session. Thus, a HIPAA special enrollment can be indistinguishable from any other addition of a spouse or dependent to existing coverage – with no "request" to the plan for a special enrollment.

To assure compatibility of the SBC requirements with this common method of online HIPAA special enrollment, we request that the regulations specify that an employer's group health plan will not fail to comply with the SBC requirements if it has posted, on the benefits website on which employees make changes to coverage, the current SBCs for *all benefit packages* offered by the employer, so that HIPAA special enrollees have immediate access to the SBC for the benefit package in which they are currently enrolled (and if the plan also offers written SBCs to the HIPAA special enrollee upon request).

We also request that the final regulations clarify that, with respect to such electronic HIPAA special enrollments, an employee's consent to receipt of the SBC in electronic form, as a step in the enrollment procedure, (1) will constitute valid consent under section 2590.715-2715(a)(4)(ii) and the corresponding provisions of the proposed regulations, which provide that "the SBC may be provided electronically if the requirements of 29 CFR 2520.104b-1 are met"; and (2) will satisfy the requirement contained in the proposed SBC instructions at 26 CFR Part 47, Appendix B-1, that an employee who conducts enrollment electronically must "acknowledge receipt of the [SBC] form as a necessary step to completing the enrollment application."

Providing SBCs upon request. Section 2590.715-2715(a)(1)(ii)(F) and corresponding provisions of the proposed regulations require that a plan "provide the SBC to participants or beneficiaries upon request, as soon as practicable, but in no event later than seven days following the request." Many employer plans contract with service providers to administer their group health plans, including the fielding of telephone and online inquiries and requests for written materials from health plan participants and beneficiaries. Although prevailing industry standards and practices usually result in the fulfillment of requests for documents within seven calendar days, circumstances also frequently arise in which such a short timeframe is difficult or impossible to meet. For example:

> Employer Z contracts with M, a worldwide benefit plan recordkeeper, for services including providing a phone bank for its group health plan's participants and beneficiaries. On the Wednesday before Thanksgiving Day, 12 participants in Z's health plan telephone the M call center and request copies of all SBCs of plans for which they are eligible. The M representatives enter data in the M computer system, requesting "calculations" and a report of the plans for which the Z callers are eligible. The reports are run and transmitted to M's document fulfillment vendor, which generates the appropriate SBCs and prepares their mailing to the Z participants and beneficiaries. Because of the four-day (Thursday-Sunday) delay owing to the holiday, M's vendor mails the SBCs on the following Thursday, two days after the expiration of the section 2590.715-2715(a)(1)(ii)(F) seven-day period. Under the proposed regulations, Employer Z is potentially liable for penalties totaling up to $24,000 (a two-day failure for 12 participants).

We respectfully request that the final regulations expand the seven-day deadline for providing SBCs upon request (including for HIPAA special enrollments), to a period of at least 10 calendar days or seven business days.