EBMS
Employee Benefit Management Services, Inc.

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Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653, US Dept. of Labor
200 Constitution Ave NW
Washington, DC 20210

Attn: RIN 1210-AB52

To Whom It May Concern:

Employee Benefit Management Services, Inc., (EBMS), is a third party claims administrator for self-funded employer group health plans. EBMS appreciates the opportunity to offer comments to the Department of Labor, Department of Health and Human Services, and the Department of Treasury (the "agencies") in response to the proposed regulations for the Summary of Benefits and Coverage and the Uniform Glossary.

1. Delayed Effective Date

EBMS suggests that the agencies delay the effective date for entities to provide a summary of benefits and coverage explanation ("SBC"). The proposed regulations were published five months late, and developed by and for the insurance industry. Given the amount of clarification necessary to appropriately implement these regulations and the lack of "shopping" between employer sponsored, self-funded group health plans, EBMS suggests a delayed effective date of January 1, 2014, when the State Insurance Exchanges come into play.

At this time, most employees are offered a benefit package from his/her employer. They may have choices between certain benefit options, but there is no "shopping" between the employer plans and any other plan. The information contained in the proposed SBC would just cause confusion and misunderstanding for the employee who is not "shopping" for benefits.

EBMS believes that the appropriate time to implement the SBC for self-funded group health plans is in 2014 when the State Insurance Exchanges will be operational and may be a valid choice for an employee. In the alternative, at the very least, an extended effective date to the first day of the Plan Year beginning on or after March 23, 2012, is necessary. EBMS believes

additional time is required to prepare for the confusion among plan members regarding the defined terms in the Glossary (the Glossary uses common insurance definitions and not necessarily those used by the self-funded industry).

EBMS further suggests that the agencies consider additional time even beyond this proposed delay in the effective date, for: 1) enforcement of any penalties associated with Section 2715 for noncompliance; and 2) to allow for additional comment from organizations and entities that represent self-funded employer sponsored group health plans.

2. Proposed SBC Format and Uniform Glossary Terminology as Model Language Only

EBMS suggests that the agencies consider the proposed SBC format and uniform glossary terminology developed by the NAIC committee as model language and formatting requirements only. The proposed SBC format and glossary terminology were designed with the insurance industry in mind and, in particular, the individual insured market. Neither one represents the needs of the self-funded group health plan market, and in some cases, the fully insured group health plan market. The proposed SBC format will undoubtedly be very helpful to individuals attempting to decide between several options of different insurance carriers, both now and when the exchanges come into existence. The proposed SBC format and glossary terminology has little value however, to employees of a larger employer. Any "shopping for coverage" by the employees of larger employers is limited to selecting between the different benefit options offered by the employer. Many employers offer one group health plan with a different benefit level when a network provider is utilized vs. a non-network provider. In this case, benefit design can simply vary the annual out-of-pocket maximums, deductibles, coinsurance levels, or any combination of the three. The proposed SBC format does not easily accommodate this very common benefit design. If sponsoring employers are required to use the proposed SBC format without any modification, this will force employers to provide additional benefit summaries in order to correct inaccurate, confusing, and misleading benefit information - all at enormous costs to an employer community already struggling with the costs of healthcare reform.

Additionally, for those group health plans subject to ERISA, the proposed regulations disregard what current law considers the "plan document". The "plan document" can include all written documents that describe benefits. A plan document clearly describes benefits to which employees may be eligible. Forced compliance with an SBC format that is inaccurate, misleading, and inconsistent with the terms of the governing plan documents can "modify" benefits where no modification was intended.

EBMS suggests that as long as the SBC generally meets the broad content requirements of Section 2715, the sponsoring employer should have the flexibility to design an SBC format and glossary terminology to be consistent with the employer's governing plan documents. Self-

funded employer sponsored group health plans will not be "sold" on the exchanges, and once automatic enrollment becomes effective, these employees will have no opportunity to "shop for coverage". Therefore, sponsoring employers should have the flexibility offer an SBC to employees in a format that gives employees accurate information on which to make critical decisions about coverage.

Specific examples of the incongruities of the proposed SBC format and glossary terminology are as follows:

- The term "premium" has an entirely different meaning to the employee of a large employer than to someone shopping for individual insurance coverage. Employees of a large employer typically make a contribution to coverage. This contribution is calculated in several ways, most commonly as a percentage of a premium-like amount, a fixed dollar amount updated on renewal by the employer, or by the state legislature for some non-federal governmental employers.

- The proposed terminology for "medically necessary" is inconsistent with required defining language for medical necessity in some states. Does a self-funded non-federal governmental employer provide benefit summaries compliant with state law requirements or with the terminology proposed by the NAIC?

- The section entitled "Your Rights to Continue Coverage" is misleading and incorrect with respect to the group health plan market, including both the insured and self-funded group health plans. Of the events listed, only the commission of fraud will cause a loss of coverage to the employee participant. Neither of the other two events will apply to an employer plan. Sponsoring employers should have the flexibility to modify this language to meet the requirements for loss of coverage in the group health plan market.

- The section entitled "Your Grievance and Appeals Rights" is incorrect for self-funded group health plans subject to ERISA. Also, some non-federal governmental employers may be subject to state insurance requirements for a grievance procedure for complaints, but many states do not make this requirement of non-federal self-funded governmental employers. The claims review regulations published in 2000 by the DOL, and as amended by PPACA, contain extensive requirements for the right to appeal, but make no mention of any requirement to offer additional procedures for grievances.

Additionally, the recommended format for the "Coverage Examples" section is misleading and will confuse employees with inaccurate information on plan benefits. Sponsoring employers should have flexibility to change the format, including limiting the number of examples, to provide meaningful information for employee participants. For example, when benefit design applies different cost-sharing amounts for use of a non-network provider, the proposed format does not accommodate the difference in costs to an employee participant when a non-network

provider is used vs. a network provider. To include additional examples would make an already cumbersome format completely unworkable, and would certainly not achieve the desired result of assisting employees to make informed decisions. In order to accommodate the number and type of examples that the agencies contemplate in the proposed regulations, sponsoring employers should have the flexibility to utilize different methods to deliver this information. Methods should include any reasonable method, written or electronic, such as an interactive web-based product, as long as information on how an employee can access this information is included in the SBC.

EBMS suggests that as the agencies consider modifications to the format of the SBC and the uniform glossary of terms that, in addition to the NAIC, the agencies include representation from the self-funded group health plan market. The needs of the employee participants of larger employers are very different in many respects to the needs of individuals shopping for an individual insurance policy.

3. Clarify that "premium" for the group health plan market, self-funded and insured, means the contribution amount for the employee participant to enroll in coverage.

EBMS suggests that the agencies clarify the requirement to provide premium information (for self-insured group health plans, the "cost of coverage") to mean the employee contribution amount only (actual cost to an employee net of any employer contribution) for a benefit option. For employee participants to make an informed decision between two or more benefit options, and even a tier of coverage (employee-only, employee plus spouse, employee plus children, or family), the amount the employee must contribute towards coverage will be the most helpful information for employees. EBMS further notes that the agencies should make clear that the "cost of coverage" as it set forth on the SBC is not to be confused with the "cost of coverage" included on the employee's W-2.

4. Make distribution requirements for the SBC consistent with existing distribution requirements for the summary plan description.

Section 2715 requires distribution of the SBC to individuals at the time of application, to enrollees before enrollment or re-enrollment, as applicable. For the group health plan market, insured and self-funded, distribution of benefit options typically occurs at the time of enrollment as a new hire, at special enrollment, and if offered by the employer, at open enrollment. Section 2715 makes no reference to any requirement to distribute an SBC upon request. The agencies have determined that there should be some time period for distribution upon the request of an employee participant. EBMS does not disagree with the agencies' interpretation that a time period for distribution upon request is necessary, but EBMS suggests that the better and more consistent approach is to match the time periods set forth in 29 CFR 2560.502c-6 for request under ERISA Section 104(a)6. The sponsoring employer should be considered to be compliant in the distribution of an SBC if provided no later than the 30th day following receipt of the request.

EBMS also asks the agencies to clarify that the "designated administrator" is the Plan Administrator, as that term is defined in ERISA Section 3(16)(A).

5. Exempt all Health Flexible Spending Arrangements, Health Reimbursement Arrangements, Wellness Programs, Employee Assistance Programs and Stand-Alone Dental and Vision Plans.

The proposed SBC format and uniform glossary of terms is not usable in its present form for Section 125 health flexible spending arrangements, health reimbursement arrangements, wellness programs (often offered in conjunction with a health reimbursement arrangement), employee assistance programs and stand-alone dental and vision plans. Health reimbursement arrangements by design must be fully funded by the sponsoring employer. Employee assistance programs are also fully funded by sponsoring employers. Health flexible spending accounts are an optional election for an employee, and will as of January 1, 2013, be limited to $2,500 in total contributions. Given that these programs are limited in scope and benefits, will never be "sold" on exchanges and, for health reimbursement arrangements, wellness programs, and employee assistance programs, funded entirely by the sponsoring employer, EBMS suggests that these benefit arrangements be excluded as a class from all requirements of Section 2715.

6. Clarify that, for self-funded group health plans, the requirement to give 60 days prior notice of a material modification to the terms of the plan does not require distribution of a new SBC and certain circumstances should permit relief from the 60 day advance notice requirement.

For group health plans subject to ERISA, the 60 day advance notice requirement differs from the notice provisions outlined in 29 CFR 2520.104b-3, for the summary of material modifications (not later than 210 days after close of the plan year) and notice of a material reduction in benefits (within 60 days after adoption of the change). Section 2715 requires 60 days advance notice of a material modification in benefits. In the proposed regulations, the agencies have interpreted this advance notice requirement to also require updating and redistributing the SBC.

Currently in the self-funded group health plan market, benefit changes can occur up to the beginning of the plan year. Particularly given the new requirements of PPACA (prohibition against lifetime and annual dollar limits, prohibition against pre-existing conditions, etc.), employers must redesign benefits numerous times in order to offer a benefit design that employees and employers can afford. Currently, notice of material changes in benefits is provided during open enrollment (typically 30 days prior to the beginning of the plan year) to help employees choose between benefit options, or in the event of a mid-plan year reduction in benefits, within 60 days of the date of adoption.

EBMS does not disagree with the 60 day advance notice requirement, but suggests that the agencies delay the effective date for this requirement to allow the industry time to adapt to the required 60 day advance notice period.

EBMS further suggests that the agencies allow employers to use any reasonable written or electronic method, including updating and redistributing the SBC, to give notice of material modifications to benefits. A material modification to benefits should retain the definition in ERISA Section 102, which generally includes any modification to coverage that independently or in conjunction with other changes, would be considered by the average employee participant to be an important change. Material modifications can include benefit enhancements, changes in cost-sharing provisions, or a change that substantially reduces or eliminates benefits for the treatment of a specific illness or condition. Any of these modifications could be "significant" to the average employee participant, depending upon individual circumstances. Consider for example, a modification to exclude all alternative care benefits (including massage therapy, naturopathic treatments, and acupuncture, among others). This modification may be "material" to someone who uses certain naturopathic treatments for a chronic condition. However, to revise and redistribute the SBC for this modification is a waste of employer resources and does not give notice of this benefit reduction to employees. The Draft Instruction Guide for Group Policies instructs the sponsoring employer to reference only the "required list of services" and no others. This list includes acupuncture and chiropractic care, but not naturopathic treatments or other forms of alternative medicine. Therefore, a reduction of these benefits, while "material" to some employee participants, will not be referenced on the proposed SBC format. EBMS suggests that the agencies permit the employer to use any reasonable written or electronic form of communication to give notice of a material modification to employees, and to not require revision and redistribution of the SBC as that means of notification.

7. **Clarify that electronic distribution of an SBC to the employee participant is sufficient to meet the DOL requirements to ensure that information is sent by means "reasonably calculated to result in actual receipt".**

The proposed regulations suggest that for those plans subject to ERISA, the SBC can be distributed electronically if the requirements of the Department of Labor's electronic disclosure safe harbor are satisfied. The Department's safe harbor imposes strict requirements for electronic distribution, including an affirmative consent requirement where the recipient is not an employee. It would be nearly unworkable and could only occur at significant cost to the employer to attempt to apply the special consent requirement to a spouse or other dependent with no access to the employer's information systems and network. Section 2715 does not contemplate automatic distribution to beneficiaries, but rather to the "applicant", "enrollee", "policy holder" and "certificate holder". EBMS suggests the agencies clarify that these terms mean the individual serving as the primary subscriber, such as the employee participant.

8. Clarify that SBC can be provided within the summary plan description.

EBMS suggests that the agencies permit the sponsoring employer to include the SBC within the summary plan description.

Thanks in advance for your consideration of our written comments.

Sincerely,

Terri Hogan, JD, MBA
Employee Benefit Management Services, Inc.