WELLS FARGO

October 21, 2011

Via E-mail: E-OHPSCA2715.EBSA@dol.gov

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
Attention: RIN 1210-AB52

Re: RIN 1210-AB52, Summary of Benefits Coverage and the Uniform Glossary

Ladies and Gentlemen:

Thank you for providing Wells Fargo & Company ("Wells Fargo") the opportunity to respond to the notice of proposed rulemaking and solicitation of comments regarding the summary of benefits and coverage ("SBC") and the uniform glossary, which were jointly issued by the Department of Labor, Internal Revenue Service, and Department of Health and Human Services (collectively, the "Departments") in the *Federal Register* on August 22, 2011 (the "Proposed Rule").[1] Wells Fargo is providing this response letter solely in its capacity as plan sponsor of an ERISA-covered group health plan.

Our response is focused on the Departments' request for comments regarding factors that affect the feasibility of implementing the SBC and uniform glossary within the timeframe specified in section 2715 of the Public Health Service Act (the "PHS Act").[2] For the reasons described below, we recommend that the Departments adopt the position that the requirements of section 2715 of the PHS Act will not be applicable to employer-sponsored group health plans until twelve months after the Departments' promulgation of a final regulation. We also request that the Departments issue a technical release as soon as practicable to reflect this position and provide certainty to the group health plan community.

I. Background on Wells Fargo's Group Health Plan Communications

Currently, Wells Fargo employs approximately 275,000 individuals, known as Wells Fargo's "team members." Wells Fargo sponsors an ERISA-covered group health plan (the "Plan") that provides health benefit coverage to eligible team members and their eligible dependents. The Plan allows participants to choose from a number of different health benefit coverage options. Some of the health benefit coverage options under the Plan are self-insured and others are fully-insured.

[1] 76 Fed. Reg. 52,443 and 52,475.

[2] *See* 76 Fed. Reg., at 52,444 and 52,452.

Wells Fargo agrees that it is important for participants of group health plans to have accurate information about their health benefit coverage. In addition to the summary plan description required under ERISA, Plan administration has developed comprehensive and detailed materials to communicate with participants about the coverage options available to them under the Plan:

- Three-page summaries of each available coverage option, which include information about the annual deductible, annual out-of-pocket maximum, and coinsurance for in-network and out-of-network services;

- A rate list showing the employee's cost of coverage for each available coverage option and each corresponding coverage level under the Plan;

- A customized personal enrollment guide containing information about current Plan enrollment and the coverage options available the following Plan year, including incorporating the three-page summaries of available coverage options and cost of coverage information (provided only in connection with annual benefits enrollment); and

- A new hire kit (provided only when a team member is initially eligible to enroll in the Plan).

These materials are also generally available online through the Plan's continuous access website. In addition, Plan administration maintains an interactive online comparison tool that allows participants to compare available health benefit coverage options based on coverage level and anticipated use of covered health care services during the year. We believe these materials are helpful to our Plan participants in deciding which coverage option to choose and understanding their health benefit coverage under the Plan.

II. The SBC and Uniform Glossary Should Not Be Applicable to Employer-Sponsored Group Health Plans Until Twelve Months After the Promulgation of a Final Regulation.

We have concerns about certain aspects of the Proposed Rule, including the challenges in applying the templates, instructions, and related materials developed by the National Association of Insurance Commissioners ("NAIC") to the self-insured group health plan context.[3] However, we have focused our response on the Departments' request for comments regarding factors that affect the feasibility of implementation within the timeframe specified in section 2715 of the PHS Act.

We recommend that the Departments adopt the position that the requirements of section 2715 of the PHS Act will not be applicable to employer-sponsored group health plans until twelve months after the promulgation of a final regulation. We also request that the Departments

[3] As the Departments noted, the SBC template and related documents were drafted by the NAIC primarily for use by health insurance issuers, not by self-insured group health plans. 76 Fed. Reg., at 52,444. For example, the SBC template includes concepts that are generally not relevant for self-insured group health plans, including terms like "policy," "premium," and "grievance."

issue a technical release as soon as practicable to reflect this position and provide certainty to the group health plan community.[4]

We are concerned that the Proposed Rule does not provide sufficient certainty for group health plans to begin preparing for compliance with the SBC requirement at the present time. Based on the comments we anticipate the Departments will likely receive, key elements of the Proposed Rule could be materially changed when final regulations are ultimately issued, particularly in the context of group health plans. Failing to provide adequate time for group health plans to prepare for compliance after issuance of a final regulation could result in substantial inefficiencies. For example, plan sponsors could spend significant resources to build systems that include the cost of coverage on the SBC, only to find that this requirement is modified or eliminated in the final regulation. Only after a final regulation is issued will group health plans have the certainty needed to engage in the systems design and testing on the required content of the SBC.

Group health plans will need time to evaluate final regulations and prepare for compliance, and twelve months is a reasonable period of time. In addition to systems design and testing, group health plans will likely need to consult with their self-insured claims administrators to ensure that the information included in the SBC is accurate. Group health plans will also need to have time to review existing participant disclosure materials to identify potential redundancies with the SBC. Providing participants with too many redundant materials could result in confusion. Finally, group health plans may wish to communicate with participants in advance about changes to plan disclosure materials in light of the SBC requirement, particularly where participants are familiar with customized plan disclosure materials that will no longer be provided. Twelve months from issuance of final regulations should provide adequate time to complete these items.

The language of the PHS Act contemplates that group health plans would have at least twelve months from the Departments' issuance of final guidance on the SBC to prepare for compliance. Section 2715(a) of the PHS Act provides that the SBC standards would be finalized no later than twelve months after the date of enactment of the Patient Protection and Affordable Care Act ("PPACA") (*i.e.*, no later than March 23, 2011). Section 2715(d) of the PHS Act provides that group health plans would not be subject to the SBC requirement until twenty-four months after the date of enactment of PPACA. Under this timeframe, the PHS Act itself provides group health plans twelve full months to comply with the SBC standards, which we believe is the minimum amount of time necessary for group health plans to prepare for compliance.

In similar contexts, the Departments have already delayed the applicability dates of aspects of new PPACA requirements. For example, the Department of Labor issued several pieces of interim guidance delaying aspects of its interim final regulation regarding internal

[4] In the event the Departments do not intend to extend the compliance date beyond the timeframe contemplated by section 2715 of the PHS Act, we request that the Departments provide clarification as soon as practicable.

claims and appeals and external review to address implementation timeframes.[5] The IRS also issued guidance providing interim relief from the requirement to report the aggregate cost of applicable employer-sponsored coverage on Form W-2 and delayed compliance with the requirement of section 2716 of the PHS Act until guidance is issued.[6] As with these prior situations, because the administrative penalties for failure to comply with the SBC requirements could be severe, the Departments should provide group health plans with twelve months from the issuance of final regulations to comply with the SBC requirements.

* * *

Wells Fargo appreciates having the opportunity to comment on the Proposed Rule. We hope this response letter has provided useful information to the Departments in connection with understanding how the Proposed Rule will impact employer-sponsored group health plans and their participants.

Sincerely,

Justin Thornton
Senior Vice President,
Head of Corporate Compensation &Benefits
Wells Fargo & Company

[5] DOL Technical Release No. 2010-02 (Sept. 20, 2010); DOL Technical Release 2011-01 (Mar. 18, 2011).

[6] IRS Notice 2010-69; IRS Notice 2011-1.