



**National
Business
Group on
Health**

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

October 21, 2011

Submitted electronically via: www.regulations.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

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9982-P
P.O. Box 8016
Baltimore, MD 21244-1850

CC:PA:LPD:PR (REG-140038-10)
Room 5205
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Proposed Regulations Regarding Disclosure of the Summary of Benefits and Coverage and Uniform Glossary under the Patient Protection and Affordable Care Act

Dear Sir or Madam:

The National Business Group on Health is pleased to comment on the proposed regulations regarding the Patient Protection and Affordable Care Act's (Affordable Care Act's) requirements for disclosure of the summary of benefits and coverage (SBC) and uniform glossary for group health plans and health insurance coverage.

The National Business Group on Health represents approximately 330 primarily large employers, including 67 of the Fortune 100, who voluntarily provide health benefits and

other health programs to over 55 million American employees, retirees, and their families.

The National Business Group on Health supports the Department of Labor's, the Department of Health and Human Service's, and the Department of Treasury's (collectively, the Departments') efforts to provide plan participants and beneficiaries with clear, consistent, and comparable information about their health benefits and coverage.

However, our members are concerned that the proposed SBC and uniform glossary will duplicate and, in some cases, conflict with existing plan disclosures required under the Employee Retirement Income Security Act of 1974 (ERISA), thereby causing confusion for plan participants. Furthermore, as our members prepare for

implementation of the Affordable Care Act's SBC and uniform glossary requirements, a primary concern will be minimizing the administrative and cost burdens associated with these requirements. Allowing plan sponsors flexibility to adapt their compliance procedures to existing plan disclosures will reduce these burdens and allow plan sponsors to devote more resources toward maintaining and improving health benefits for their employees. **Therefore, the National Business Group on Health supports:**

- (1) Allowing group health plans to incorporate the SBC and uniform glossary into existing plan disclosures required by ERISA;**
- (2) Allowing self-insured plans flexibility to adapt the SBC and uniform glossary to their specific plan designs and plan language;**
- (3) Allowing group health plans additional flexibility in distributing SBCs electronically;**
- (4) Eliminating the requirement that plans provide customer assistance processes with oral language services in non-English languages;**
- (5) Eliminating the requirement that plans include in each notice a statement in the relevant non-English language about the availability of language services; and**
- (6) Delaying the effective date of the SBC and uniform glossary requirements to the first day of the first plan year beginning at least 12 months after the issuance of final regulations.**

We believe that these provisions will minimize confusion for plan participants, reduce administrative and cost burdens, and allow plan sponsors much-needed flexibility in preparing and distributing SBCs and the uniform glossary. We provide further discussion of these recommendations and address the Departments' specific requests for comments below.

I. SBCs and Current Required Disclosures

National Business Group on Health members employ and provide health benefits for employees under a wide variety of work arrangements, including full-time, part-time, seasonal, and temporary. Our members often operate multiple lines of business in multiple locations (sometimes in all 50 states). To accommodate the health care needs of their large and varied employee populations, our members provide a wide variety of health plan options at different cost and coverage levels. Our members also have devoted significant financial, administrative, and staff resources to their health plan communications and disclosures. In efforts to engage and educate participants in health and coverage choices, our members' health plan communications and disclosures are often more extensive and comprehensive than those required by ERISA's minimum disclosure requirements. For example, many of our members, in addition to providing timely summary plan descriptions (SPDs) and summaries of material modification (SMMs), conduct annual health plan information sessions, maintain telephone hotlines where participants can obtain assistance with health plan enrollment, and provide Internet-based tools that allow participants to compare and select their health plan options. Our members are very concerned that the proposed SBC and uniform glossary will duplicate existing disclosures and communications and cause confusion for plan participants and beneficiaries. Our members' concerns include the following:

- Unlike health coverage in the individual and small group markets, our members' health plans often make numerous benefit packages with different premium, coinsurance, deductible, and copayment levels available to employees. Cost-sharing levels and coverage options also may vary with employees' compensation. If employers offer consumer-directed health plans with health accounts, the amounts that plan participants pay for services depends on a number of factors, including whether they have met their deductibles and whether they have reached out-of-pocket maximums. Thus, a single group health plan (and a single participant) may have dozens of "benefit package" options. Developing and distributing separate SBCs for each benefit package will involve significant financial and administrative costs for our members.
- ERISA already requires that an SPD be "written in a manner calculated to be understood by the average plan participant" and "sufficiently comprehensive to apprise the plan's participants and beneficiaries of their rights and obligations under the plan." 29 C.F.R. § 2520.102-2(a). The SBC and uniform glossary would duplicate information in the SPD and current plan enrollment materials, thereby increasing plans' costs and administrative burdens.
- Participants and beneficiaries likely will be confused by receiving numerous SBCs that duplicate information in SPDs and other plan enrollment materials.

- Because of the stringent requirements of ERISA’s current electronic disclosure safe harbor (such as requiring affirmative consent when accessing an electronic information system is not an integral part of a participant’s duties as an employee), many of our members will not be able to distribute SBCs electronically to minimize costs of distributing SBCs.

For the reasons described above, the National Business Group on Health recommends:

- (1) Allowing group health plans to incorporate SBCs into SPDs—thereby resulting in a single, comprehensive document that allows participants to compare benefit package options—provided the document satisfies the content and formatting requirements specified in Section 2715 of the Public Health Service Act (PHSA);
- (3) Providing in final regulations a safe harbor under which plans that already provide tools to compare benefit packages (such as Internet-based comparison tools) will be deemed to have satisfied the requirements of PHSA § 2715, provided the plans comply with the content requirements of PHSA § 2715;
- (4) Instead of requiring compliance with ERISA’s electronic disclosure requirements in 29 C.F.R. § 2520-104b-1(c), allowing group health plans to provide SBCs electronically to *all* plan participants and beneficiaries as long as the method of electronic disclosure is “reasonably calculated to ensure actual receipt of the material by plan participants, beneficiaries and other specified individuals,” 29 C.F.R. § 2520-104b-1(a), and provided plans make paper copies available upon request.

II. Contents of the SBC and Uniform Glossary

In addition to the above concerns involved with integrating SBCs with existing plan communications and disclosures, our members are concerned that the SBC and uniform glossary will confuse, and in some cases, mislead participants and beneficiaries as to the terms of their health coverage. This result would run contrary to the Affordable Care Act’s goal of providing a document that “accurately describes the benefits and coverage under the applicable plan.” PHSA § 2715(a). Our members’ concerns include the following:

- Because coverage costs vary widely by geographic area and the proposed regulations require plans to use allowed charges specified in agency guidance, it is likely that for many participants, the coverage examples will not provide an accurate statement of the costs of having a baby, treating breast cancer, or managing diabetes. Even if the SBC states that the coverage examples are not a “cost estimator” and that participants should not use these examples to

estimate actual costs, participants may significantly over- or underestimate costs of health services based on these coverage examples.

- As described above, our members' plans often provide numerous benefit package options. Customizing calculations for the proposed coverage examples for each benefit package will present a substantial administrative burden for our members.
- The uniform glossary includes many terms that are not applicable to self-insured plans and therefore may cause confusion for participants and beneficiaries. For example, the uniform glossary includes references to "policy," "insurer," and "grievance," none of which are applicable to self-insured plans. Furthermore, our members' SPDs often include definitions that are more detailed and extensive than those in the uniform glossary and tailored to specific plan designs. Therefore, the uniform glossary may conflict with (or cause confusion regarding) plan terms.
- Because our members, as ERISA plan administrators, are required to adhere to plan documents and terms, current SPDs and other plan documents are carefully drafted to provide precise and accurate descriptions of plan rules and benefits. Our members are concerned that the SBC and uniform glossary will oversimplify or conflict with plan terms, thereby confusing participants and increasing burdens on the claims and appeals process and litigation risks.

For the reasons described above, the National Business Group on Health recommends:

- (1) In final regulations, allowing group health plans flexibility to (a) adapt coverage examples to their specific plan designs and cost structures or (b) provide individuals with information necessary to generate coverage examples and reference to a central internet portal to generate coverage examples, as suggested in the proposed regulations;
- (2) Allowing group health plans flexibility to (a) modify the uniform glossary to be consistent with plan terms and (b) include a statement in the SBC and uniform glossary that in the event of any conflict between the SBC/uniform glossary and plan documents, the plan documents will prevail; and
- (3) If final regulations require that SBCs and uniform glossaries be separate from other plan documents, clarifying that the SBC and uniform glossary are not "plan documents" for ERISA purposes and that plan fiduciaries retain the authority to interpret and apply plan documents.

III. Culturally and Linguistically Appropriate Manner

As noted above, our members provide health benefits for employees under a wide variety of work arrangements, often in multiple locations. Providing notices to such widely dispersed plan participants and beneficiaries involves significant administrative and cost burdens for our members.

We believe the proposed regulations' language provision, which incorporates the form and manner of notice requirements under PHSA § 2719, could result in administrative and cost burdens for plan sponsors that substantially outweigh the benefits for plan participants and beneficiaries. For example, because the proposed regulations require non-English language statements in every SBC sent to a county that meets the 10% threshold for people literate only in the same non-English language, a plan sponsor could be required to maintain a separate version of an SBC even if there is only one plan participant residing in a county that meets the 10% threshold. Likewise, the requirement to provide interpretive services in applicable non-English languages could result in a plan sponsor having to maintain such services for a single participant residing in a county that meets the 10% threshold—even if no other participants speak the applicable non-English language. In addition, a plan sponsor would have to evaluate its participant population every year to determine if plan participants have moved from counties that do not meet the 10% threshold to counties that do (or between counties where applicable non-English languages differ), thereby requiring revised SBCs and additional oral language services. These requirements will be especially burdensome for employers that operate in multiple states or multiple counties within a state.

The National Business Group on Health believes that complying with the standards of 29 C.F.R. § 2520.102-2(c), which requires non-English language *assistance* (and notice of such assistance) when, in the case of a plan covering 100 or more participants, the lesser of 500 or more participants or 10% or more of all plan participants are literate only in the same non-English language, would adequately ensure that SBCs are provided in a culturally and linguistically appropriate manner, as required by the Affordable Care Act. Many of our members voluntarily provide oral language services and notices in non-English languages when they have substantial numbers of non-English-speaking plan participants, but requiring such measures with respect to every county that meets the 10% threshold could present substantial costs with minimal benefit for plan participants and beneficiaries. For these reasons, the National Business Group on Health recommends that in final regulations, the Departments:

- (1) Eliminate the requirement that plans provide interpretive services in all applicable non-English languages;
- (2) Eliminate the requirement that plans include in each SBC a statement in all applicable non-English language(s) about the availability of language services; and

- (3) Permit group health plans to satisfy the requirements of PHSA § 2715(b)(2) by applying the requirements in the current 29 C.F.R. § 2520.102-2(c) to SBCs.

IV. Effective Date

As discussed above, preparing and distributing SBCs will involve significant changes to our members' health plan communications processes, particularly during annual open enrollment periods. If final regulations require preparing separate SBCs for every benefit package, our members will need time to finalize plan offerings, prepare potentially dozens of SBCs, and distribute the SBCs to participants and beneficiaries. Our members are very concerned that the current March 23, 2012 effective date does not allow adequate time to complete this process. Therefore, we recommend delaying the effective date or delaying enforcement of the SBC and uniform glossary requirements to the first day of the first plan year beginning at least 12 months after the issuance of final regulations.

Thank you for considering our comments and recommendations on the proposed regulations regarding requirements for disclosure of the SBC and uniform glossary. We look forward to working with you as you continue to implement the various provisions of the Affordable Care Act. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012 if you would like to discuss our comments in more detail.

Sincerely,



Helen Darling
President