NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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To Whom It May Concern:

The National Coordinating Committee for Multiemployer Plans (the NCCMP) submits these comments to the Proposed Rule on Summary of Benefits and Coverage and the Uniform Glossary (Proposed Rule), published by the Departments of Labor (DOL), Treasury and Health and Human Services on August 22, 2011, to implement a new section of the Public Health Service Act (PHSA) (Section 2715) created by Patient Protection and Affordable Care Act (the Act).

The NCCMP is the only national organization devoted exclusively to protecting the interests of the approximately 26 million workers, retirees, and their families who rely on multiemployer plans for health and other benefits. The NCCMP's purpose is to assure an environment in which multiemployer plans can continue their vital role in providing benefits to working men and women. The NCCMP is a nonprofit, non-partisan organization, with members, plans, and plan sponsors in every major segment of the multiemployer plan universe.

Overview of Multiemployer Plans

Multiemployer plans are established and maintained pursuant to collective bargaining agreements between one or more unions and at least two employers. Typically structured in accordance with section 302(c)(5) and (c)(6) of the Taft-Hartley Act, the plans are operated through stand-alone trusts managed by a joint labor-management Board of Trustees with an equal number of union and employer representatives. They serve participant populations in industries where employment is historically mobile. While most often associated with the building and construction and trucking industries, multiemployer plans are pervasive throughout the economy including the agriculture; airline; automobile sales, service and distribution; building, office and professional services; chemical, paper and nuclear energy; entertainment; food production, distribution and retail sales; health care; hospitality; longshore; manufacturing; maritime; mining; retail, wholesale and department store; steel; and textile and apparel production industries. Participants often move from one contributing employer to another and would not be eligible for health coverage without the pooling effect of the multiemployer plan.

The multiemployer plan enables small employers (which typically are the employers contributing to these plans) to pool their resources, and mobile employees to pool their service with many different employers, to achieve the critical mass to make it cost efficient to provide group health plan coverage.

In multiemployer plans, the individual employer's role is typically limited to contributing the amounts required by the collective bargaining agreement, which are usually pegged to the intensity of work by covered employees (e.g., $6 for each hour of covered service). The board of trustees, acting together, make all plan design and operational decisions including eligibility, coverage, administration, funding (insured, administrative-services-only (ASO) arrangements, partially insured, or fully self-insured), selection of the plan's benefit delivery systems, and selection of the plan's service providers and advisors. Most plans operate on a self-insured basis, but some provide at least some benefits through health insurance issuers.

The eligibility rules of multiemployer plans reflect the nature of the industry in which the participants work. The plan's Trustees typically establish a work period, with work during that period leading to a later coverage period. Many plans have a lag period between the end of the work period and the effective date of coverage (i.e., the start of the coverage period), to allow reports from the contributing employers to be prepared and sent along with their required contributions to the plan and to allow the plan to determine eligibility. Once hours have been counted and eligibility determined, coverage typically takes effect at the start of the coverage period, on the first day of a month, without the participant needing to enroll or take affirmative action. Coverage is provided during the full period for which the person is eligible, even if he or she is no longer working in the industry by the time the coverage period begins (with applicable coordination of benefits). Employees who regularly work in the industry maintain continuous coverage, even if they frequently change covered jobs.

As an example, a multiemployer plan may require that a participant work 300 hours in a 3-month work period to gain eligibility in a subsequent coverage period. Typically, work performed in a calendar month is reported by the contributing employers by a specific date (e.g., the 20th day) in the subsequent month. Therefore, if an employee completes the necessary hours to meet this standard based on hours worked from January through March, the plan would receive documentation and March contributions by April 20, and the employee would be eligible for the May-July coverage period. The established periods reflect the ebb and flow of work availability in the particular industry. Because of this rolling eligibility, where workers gain coverage when they meet the plan's eligibility requirements, multiemployer plans typically do not conduct annual open enrollment.

Executive Summary

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.

I. The Agencies Should Immediately Announce A Delayed Effective Date Plan Sponsors To Distribute The SBC Until The First Plan Year That Begins 12 Months After The Effective Date Of The Final Rule

The current template SBC, Instruction Guide and Uniform Summary will require significant modification in order to reflect the operations of self-insured plans. Consequently, we request that plan sponsors have a delayed effective date for compliance until the first plan year that begins 12 months after the effective date of the Final Rule. In particular, this will allow self-insured plans time to consider any necessary modifications prior to completing the SBC. Distributing SBCs at the beginning of the plan year will mean that the distribution schedule is on the same timetable as for other plan materials, as well as make sure that the initial SBC that is distributed is the most up to date for the upcoming plan year. Prior to this suggested effective date (the plan year that begins 12 months after the effective date of the Final Rule), plans would not be required to create and provide the SBC to new participants, due to the fact that it would create confusion between participants as to the correct plan documents.

We request that the agencies adopt and announce this delayed effective date immediately. Plan sponsors have already begun to review the SBC guidelines, but they cannot begin to actually draft SBC documents until the format is final. Plan sponsors should be able to judiciously evaluate the application of the SBC to their plan and the methodology for delivery, and they will need time to accomplish this task.

II. A Template of the Summary Benefits and Coverage, Uniform Glossary and Draft Instruction Guide Should be Created that Reflects Self-Insured Plans in General and Multiemployer Plans in Particular

As the Departments recognize in the preamble to the Proposed Rule, changes to the template SBC and related documents may be necessary to accommodate group health plans that are not fully-insured. This is particularly the case because "the SBC template and related documents were drafted by the NAIC primarily for use by health insurance issuers." 76 Fed. Reg. 52442, 52444 (August 22, 2011).

A significant number of multiemployer plans are self-insured group health plans, and would be required to provide SBCs to their participants and beneficiaries. However, it is proving very difficult for self-insured plans, and particularly multiemployer plans, to describe their benefits using the insurance terminology and concepts that are required by the mandatory template SBC and related documents drafted by the NAIC.

Below are examples of how the SBC template and related documents fail to accurately describe self-insured group health plan benefits, including multiemployer plans:

- The header on the template SBC states: "This is not a policy. You can get the policy at www.insurancecompany.com. . . ." and provides for the "Policy Period." This terminology

- does not reflect a self-insured plan, which is not a "policy" and which does not have a "policy period." Rather, it is a "plan" with a "plan year."

- Throughout the template SBC, and particularly the sample version that is filled out, there are references to "insurers," "health insurance" or "policy," which should not be included in a SBC that describes a self-insured plan. Moreover, terms such as "plan administrator" "fund," or "fund office" would need to be used in a SBC provided by a multiemployer plan.

- The first question in the template SBC is "What is the premium?" Self-insured plans do not charge a "premium," and multiemployer plans often require no employee contribution at all directly from the plan's participants as such costs are typically derived from an allocation from the negotiated wage package. For a self-insured plan, the proper question would be "What is the participant/employee's contribution?" However, as explained below in Section I.B, multiemployer plans should not be required to provide premium or cost of coverage information in the SBC.

- The "Your Rights to Continue Coverage" section does not reflect continuation coverage in the context of ERISA[1] plans. Significantly, it does not mention the right to continuation coverage under COBRA[2] or USERRA.[3] 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.

- As PHSA Section 2715 does not require that grievance, claims and appeals rights be addressed in the SBC, the "Your Grievance and Appeals Rights" section should be eliminated from the template SBC. However, if the Departments decide to keep this section, it should be revised for purposes of self-insured plans. Significantly, this section does not reflect or refer to the internal claims and appeals rights provided under the DOL Claims Procedures, 29 CFR 2560.503-1, as amended by the Act, or the right to external review, which are required for multiemployer plans other than grandfathered plans. In addition, it does not use terminology that is applicable to self-insured plans, such as a "claim," rather than a "grievance." A grievance is significantly different from an ERISA claim (and in the context of multiemployer plans has a meaning and may involve a formal process under labor law which is quite distinct from claims appeals), as opposed to an event where the participant claims a benefit. As this section does not provide the participants and beneficiaries of a self-insured plan with any of the information they would need to perfect a claim and file an appeal, it should be eliminated or 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 Draft Instruction Guide for Group Policies ("Instruction Guide") provides instructions for insurance companies/issuers, but not plan administrators. There are also references to

[1] "ERISA" means the Employee Retirement Income Security Act of 1974.
[2] "COBRA" means Consolidated Omnibus Budget Reconciliation Act of 1986.
[3] "USERRA" means Uniformed Services Employment and Reemployment Rights Act of 1994.

"employers," which are not relevant in the multiemployer context. Without guidance, self-insured plans and multiemployer plans will have to interpret these instructions to fit their unique structure and circumstances.

- The Uniform Glossary defines terms that are unique to fully-insured health plans and irrelevant to self-insured plans. These terms include Grievance, Health Insurance, and Premium. *See below* at Section I.C. for complete comments about the Uniform Glossary.

- There is no place in the template SBC that explains how this document fits in with the Plan document and Summary Plan Description (including any Summaries of Material Modification) that participants in self-insured plans receive. This type of information needs to be provided so that participants in self-insured plans understand the purpose of the SBC, as well as understand that the terms of the Plan document and/or SPD govern over the SBC. Alternatively (or in addition), self-insured plans should be permitted to provide an explanatory cover letter with the SBC that explains the purpose and significance of the SBC and its relation to the plan's governing documents.

A. To Limit Additional Costs and Redundancies to Group Health Plans, as well as Participant Confusion, the Summary Benefits and Coverage and Uniform Glossary Should Be Provided in Coordination with other Plan Materials

As the Departments know, group health plans governed by ERISA, including multiemployer group health plans, have a legal obligation to provide a Summary Plan Description (SPD) to new enrollees within 90 days of enrollment, and to all participants every five years. In the intervening five years, if material modifications are made to the SPD, a Summary of Material Modifications (SMM) has to be provided. In addition, group health plans that conduct open enrollment provide information about benefits and coverage during the open enrollment process. The information that is required in the SBC is information that is already required to be in the SPD and related SMMs and/or open enrollment materials, just in a different format. As such, and as acknowledged by the Departments at 76 Fed. Reg. 52444, it may make sense to coordinate the SBC with the other plan materials.[4]

Providing the SBC with other plan materials will limit the possibility of confusing participants and beneficiaries. The coordinated information will be in one place, which will give participants the opportunity to review more detailed information if they have questions about the SBC information. Providing the SBC with other plan materials also will diminish the possibility of inadvertently providing conflicting plan information. If the documents are provided together, they are likely be prepared in tandem and cross-checked during preparation. If they are provided separately, the possibility that an innocent, but possibly important, mistake will be made is increased.

Further, and for the reasons described below, it makes sense for multiemployer plans to provide the SBC as part of their SPD.

[4] The Departments also ask for comments about coordinating materials that describe the minimum essential coverage beginning in 2014. *See* 76 Fed. Reg. at 52447-48. To avoid redundancy and participant confusion, we agree that all notices regarding minimum essential coverage, and exchange coverage and related subsidies should be coordinated in the most cost-efficient manner possible.

1. For multiemployer plans, the SBC should be able to be provided in the SPD, and distributed in accordance with SPD rules

Because of the unique features of multiemployer plans, there should be a separate distribution rule for the SBC that requires an initial separate distribution of a stand-alone SBC or as a section of the SPD, and thereafter, the SBC should be provided as a section in the SPD. Notably, the SBC should not be required to be in the front of a multiemployer plan SPD because the participants are not "buying" coverage, and therefore, they do not need to compare the terms of their plan with other plans. Further, it is important that the plan administrator have the discretion to put the information that it deems most important in the front of the SPD. Following this procedure, after the initial distribution of the SBC, the SBC should only have to be provided in the time and manner that SPDs have to be provided (not on an annual basis), except that modifications to the SBC should be provided in accordance with the 60-day rule discussed below in Section IV.

- Multiemployer plans are unique in that their assets are limited by the employer contributions that are negotiated in collective bargaining. Further, many multiemployer plans do not use electronic distribution of plan documents because their members do not have regular access to workplace computers. As such, multiemployer plans should not be required to spend their limited resources on separately publishing and mailing SBCs on an annual basis.

- Multiemployer plans are unique in that they generally do not have annual enrollment processes. Rather, their members are automatically enrolled as the plan's eligibility rules are met, and they have continuing plan coverage due to the contributions paid by on their behalf by their employers. As such, there is no mechanism through which these plans can coordinate the provision of the SBC with an annual enrollment process.

- Because Section 1001 of the Act, amending the PHSA to add Section 2715, does not appear to require annual distribution of the SBC where there is no reenrollment process, the rules for multiemployer plans should not require such annual distribution. Rather, the multiemployer plans should distribute the SBC: (1) initially, as a stand-alone document, or as part of the SPD if the plan is distributing its SPD in the plan year that the SBC is first required, and (2) thereafter, upon distribution of the SPD (which, for new enrollees is within 90 days of becoming enrolled in the plan, and for current enrollees is every five years). If there is a material modification to the SBC, the multiemployer plan will send out a separate notice describing that modification or a revised stand-alone SBC (at its option) in accordance with the 60-day rule discussed below in Section IV.

- In addition, multiemployer plans should only have to provide the SBC to those participants and beneficiaries who are entitled to receive the SPD.

B. For Multiemployer Plans, the Content of the Summary of Benefits and Coverage Should Not Include Premium Information

The NAIC has expanded the content of the SBC to include premiums for fully-insured plans. Further, the Instruction Guide provides that the participant or beneficiary should consult with the employer for information about the employee's premium contribution. Related to this

requirement, the Departments have requested comments about whether the SBC should include premium or cost information, and if so, whether and how the amount of the employee contribution should be shown. *See* 76 Fed. Reg. at 52446-47.

Multiemployer plans generally do not charge 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.

Additional issues arise with respect to coverage for retirees whose coverage is often heavily subsidized and the types of coverage they may have (pre-Medicare, Medicare, Medicare for self, but not their spouse, etc.)

C. The Uniform Glossary Should Not Be Required for Self-Insured Plans, or Alternatively, a Separate Uniform Glossary Should Apply to Self-Insured Plans

Because self-insured plan documents contain definitional sections that govern the plan's terms, the Uniform Glossary should not apply to self-insured plans. Under PHSA Section 2715(g), the Secretary is directed to develop standardized definitions for "health insurance coverage," but self-insured plans do not provide "health insurance coverage." Thus, there is no requirement that the Uniform Glossary apply to self-insured plans.

Alternatively, if the Departments decide that self-insured plans are subject to the Uniform Glossary requirement, it is imperative that the Departments prepare a Uniform Glossary that is specific to self-insured plans. As noted above, the current Uniform Glossary contains terms that not used for self-insured plans, such as Grievance, Health Insurance and Premium. These terms should not be included in a Uniform Glossary for self-insured plans. Moreover, because self-insured plans are governed by the definitions contained in the plan documents, the Uniform Glossary for self-insured plans should only include the definitions for the required terms set forth in Section 2715(g) of the PHSA, and not the additional definitions suggested by NAIC.

There is a significant concern among self-insured plans about the possibility that the generic definitions in the Uniform Glossary will conflict with or undermine the definitions that are set forth in the governing plan documents. Multiemployer plans in particular often tailor their definitions to the unique benefits provided to their participants. Moreover, ERISA-covered plans are required to apply the definitions contained in the plan documents. As such, we request that the Departments include a statement in the self-insured Uniform Glossary to the effect of the following information:

> *The purpose of this Uniform Glossary to provide you with generic definitions of certain terms that are commonly used for health care coverage. However, the definitions contained in [**Name of Plan document/SPD**] govern the specific benefits provided under*

*your Plan. If you have any questions about what a specific term means for your benefits, you need to rely on the definitions provided in [**Name of Plan document/SPD**]*.

A further consideration involves clarification that the definitions and exclusions included in the summaries which we recommend be modified so that clear references to the appropriate pages in the SPD can be substituted.

For instance, many plans include lengthy definitions in their SPD to make them clear raising questions as to so how would plans should decide which should be included in the SPD? Similarly, exclusions that are carefully described and grouped into meaningful sections (e.g., exclusions for lack of medical necessity, exclusions for custodial care). Abbreviated exclusions will accomplish the opposite of the law's intent by suggesting the exclusions listed in the summary are the only (or at least the only important) ones.

Page references with some introductory language and perhaps an example would be much more enlightening (e.g., Exclusions are specific services/supplies that are not covered by the plan. These generally fall into several broad categories, such as exclusions for custodial care. An example of custodial care might be "Transportation except a licensed ambulance service". Here a van to the doctor's office might be useful to a patient in keeping medical appointments, but there is no medical treatment in the van so it is not paid for.

D. The Final Rule Should Clarify That Self-Insured Plans May Delegate the Preparation and Distribution of Summary Benefits and Coverage and Uniform Glossary Documents to Third Party Administrators

It is often the case that multiemployer plans delegate the day-to-day administration functions of the plan to a third party administrator (TPA). In fact, some multiemployer plans have no employees and rely entirely on their TPAs to perform all administration functions of the plan. Many single-employer plans also contract with TPAs to perform the plan administration functions for their plans. As such, we request that the Departments clarify that self-insured plans may delegate the preparation and distribution of the SBC to their TPAs through contractual arrangements.

III. The Final Rule Should Provide Guidance about How Health Plan Options that Include a Combination of Self-Insured and Fully-Insured Benefits Should Prepare and Distribute their Summary Benefits and Coverage Documents

The Proposed Rule assumes the most straightforward plan design – that certain benefit options are fully insured, while others are self-insured, and instructs as to which entity needs to prepare and distribute the SBC for those benefit options. But, the Proposed Rule does not address the common and more complex plan design of a single benefit option that includes both self-insured and fully-insured benefits.

For example, if a medical benefit package offers self-insured major medical and prescription drug coverage, but fully-insured hospital coverage, how should the SBC be compiled? It would likely be confusing to participants for a separate SBC to be distributed for each component of the benefit package – how would a participant navigate if he/she received a separate SBC for the major medical, another for prescription drug coverage, and another for hospital coverage?

Further, it would not be possible for any of those component SBCs to include the proposed Coverage Examples, which require a combination of inpatient, outpatient and pharmacy services.

We recommend that for these combination plans, the plan administrator should have the discretion to complete a singular SBC that covers the various components of the benefit option if the insurer provided SBC does not accurately describe the plan. As with rules related to distribution of HIPAA Certificates of Creditable Coverage, unless the issuer otherwise agrees, it would not be feasible to require insurers to include information in their SBC that is about coverage they do not offer. But, to alleviate the administrative burden on plan administrators, insurers should be required to provide all necessary information in SBC format to the plan administrator at no cost.

The delayed effective date for plan sponsors proposed above in Section I should apply to the benefit options that offer self-insured and fully-insured benefits. This will ensure that the SBC provided to the participants and beneficiaries accurately describes all benefits offered through the applicable benefit option.

IV. The Format and Content of the Coverage Examples Should Be More Plan-Specific and Accurate

The Coverage Examples should be more flexible so that plans can provide information about the health care issues that their populations actually face, and so that the cost-sharing information is more accurate.

A. Coverage Examples Should Be Relevant to the Participant Population

The Departments acknowledge that it may be helpful to provide a mechanism for participants to obtain information about the health care services or treatment they actually need. Specifically, the Departments solicit comments about whether it would make sense to set up a central Internet portal where plans and/or participants could input plan-specific information and plans and/or participants could then generate their own coverage examples to see how the plan would cover particular instances. *See* 76 Fed. Reg. 52448.

We agree with the Departments' sentiment that more personal Coverage Examples would be beneficial to participants. However, a generic Internet portal would not be an appropriate mechanism for multiemployer plans, which tend to have participant-friendly plan designs that focus on the physical and social attributes of their participants. It is likely that a generic Internet portal developed for fully-insured plans would not be set up to account for the unique plan designs of multiemployer plans.

We recommend a far simpler solution. The Departments should issue a series of examples that reflect a variety of injury and illness types, and let plans choose between three and six examples that make the most sense for their population. For example, multiemployer plans established by the construction trades may include an example about chronic back injuries, while multiemployer plans established for office and professional workers may look to include an example about carpal tunnel syndrome. Depending on their claims experience, these plans also might include examples about diabetes, heart disease and/or cancer.

B. Coverage Examples Should Be More Accurate and not Attempt to Include Total Care Costs Charged by Hypothetical Providers

The requirement that the Coverage Examples include estimated total care costs and combined cost sharing in dollar amounts is likely to provide inaccurate and confusing information to participants, and add little value to their decision-making process. As noted on the template SBC, the Coverage Examples do not estimate the actual costs under the plan.

We recommend that the cost-sharing information be presented in a more general way and in a form and manner that actually reflects the plan's terms. For example, the document could describe treatment for diabetes, including the types of items and services that a person with diabetes would typically need to obtain, along with the relevant cost sharing for those types of treatments. Coinsurance could be shown as a percentage, while deductibles and copayments would be shown as dollar amounts per visit or per year, as applicable, without listing the total costs of care. The proposed section on sample care costs reflects, at best, costs that might be charged by a group of hypothetical providers not connected to the plan, and might be somewhat relevant only if the individual actually needed the exact level and amount of care portrayed in the examples. This information will not assist individuals in understanding how much they might actually pay for care under the terms of their plan. Indeed, this type of information could prove to be very misleading, provoking disputes with the plan administrator when actual costs do not mirror those presented in the SBC.

Finally, we suggest that HHS could help plan sponsors by establishing a tool, developed by HHS that would produce coverage facts labels. Participants could be directed to an HHS website where they could model their specific benefit package within an online system. The cost sharing inputs would then be submitted in real time to the HHS program, which would return a HHS coverage facts label online.

V. For Multiemployer Plans, the 60-Day Advance Notice Requirement Should be Revised to Reflect Operational Realities

Meeting the 60-day advance notice requirement will be difficult for multiemployer plans because it does not account for their unique operational realities.

- Multiemployer plans are managed by Boards of Trustees that typically meet quarterly or semi-annually, and those meetings are the time and place where the Boards make decisions about material modifications to plan benefits. It is often the case that the Board decisions are made less than 60 days in advance of the effective date of the material modification.

- Multiemployer plans often make retroactive plan enhancements based on appeals decisions. For example, in September the Board of Trustees may grant an appeal for a claim seeking payment for bariatric surgery that was performed in July. Upon the grant of that appeal, the Board will amend the plan to make bariatric surgery a covered service as of July. In this type of situation, there is no way to give 60 days advance notice.

- Multiemployer plans sometimes make retroactive amendments to correct a discrepancy or inadvertent error in a plan document. It is possible that sometimes this type of retroactive

amendment will affect a provision in the SBC. However, there is no way to give 60 days advance notice of this type of modification.

Due to these unique operational realities, we recommend that, for multiemployer plans, the current rule that a Summary of Material Modification (SMM) must be provided within 60 days after the adoption of a material reduction in covered services be extended to the SBC. In other words, multiemployer plans should be required to send out notice of a material modification to a SBC, whether a benefits enhancement or reduction, within 60 days of the adoption of the modification.

VI. For Uniformity Purposes, the Departments Should Translate the SBC Template, the Uniform Glossary and the Statement Regarding the Availability of Language Services into Commonly Used Non-English Languages

Building on the requirement that group health plans provide claims and appeals notices under PHSA Section 2719 in a "culturally and linguistically appropriate manner," the Departments now propose that if plan participants or beneficiaries live in a county where 10% or more of the residents are literate only in a certain non-English language, those plan participants and beneficiaries should, upon request, be provided with interpretive services and written translations of the SBC. In addition, for plan participants or beneficiaries who live in those counties, the English version of the SBC must disclose the availability of the language services in the relevant language(s). There does not seem to be a specific requirement that the Uniform Glossary also be available in the relevant non-English languages, but it seems that would be necessary to understand fully the SBC.

In order to ensure uniformity for the SBC and the related Uniform Glossary, the Departments should issue translated versions of the template SBC and Uniform Glossary, as well as the statement that should be included in the English version of the SBC informing participants of the availability of language services. If the Departments do not provide these translations, then group health plans and issuers will provide varying translations of documents that are supposed to be uniform. Further, group health plans should not be saddled with the additional expense and administrative burden of translating the required template, uniform documents into non-English languages.

Notably, under the requirements for PHSA Section 2719, the only non-English languages for which "culturally and linguistically appropriate" notices have to be provided are Spanish, Chinese, Tagalog and Navajo. However, many group health plans, including multiemployer plans, provide coverage to participants and beneficiaries who are only literate in other non-English languages, such as French, German and Vietnamese. As such, the Departments should provide the template SBC, Uniform Glossary and statement regarding the availability of language services in Spanish, Chinese, Tagalog and Navajo, as well as other commonly spoken non-English languages.

Conclusion

We appreciate the opportunity to submit comments on these important issues. Please do not hesitate to contact me if you have any questions about our comments or need additional information.

Respectfully submitted,

Randy G. DeFrehn
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