

October 24, 2011

Office of the Health Plan Standards and Compliance Assistant
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-1850

Internal Revenue Service
U.S. Department of the Treasury
Room 5205
P.O. Box 7604
Ben Franklin Station
Washington, D.C. 20044

Submitted Via Electronic Mail to E-OHPSCA2715.EBSA@dol.gov

RE: RIN 1545-BJ94
26 CFR Parts 54 and 602
Summary of Benefits and Coverage and Uniform Glossary Requirements

To Whom It May Concern:

WageWorks, Inc. (“WageWorks”) respectfully submits these comments in response to the Summary of Benefits and Coverage (“SBC”) and Uniform Glossary proposed rule [Federal Register Volume 76, Number 162 (August 22, 2011)] (the “Proposed Rules”), which identify standards for completion and distribution of the SBC set forth in Section 2715 of the new Health Service Act (“Section 2715”). We appreciate the opportunity to comment with respect to Section 2715, under which group health plans and health insurers are required to furnish SBCs in accordance with the Proposed Rules beginning March 23, 2012.

Background on WageWorks

WageWorks is an employer that provides group health plan coverage to its employees, as well as a third party administrator that administers employee benefit plans on behalf of more than 4,700 employers of all sizes throughout the nation.

Concerns and Issues Identified by WageWorks

WageWorks appreciates the agencies' efforts to seek public input prior to finalizing the Proposed Rules. As discussed more fully below, WageWorks believes that revisions and clarifications are required to align the goals of Congress set forth in Section 2715 with the realities associated with administering group health plans.

After careful review of the proposed rulemaking pertaining to SBC and the Uniform Glossary, as outlined in the Patient Protection and Affordable Care Act ("PPACA"), WageWorks respectfully submits comments for consideration that focus on the following six main concerns:

1. The nature of the Proposed Rules;
2. Duplication between ERISA compliance requirements and the newly created SBCs;
3. Delay of the effective date of the Proposed Rules until the open enrollment period for the Plan Year that begins on or after 12 months following the date the final rules are released;
4. Relaxation of electronic distribution requirements;
5. Require that the SBC to be furnished to "participants" only; and
6. Clarification of the application of the SBC to Health Reimbursement Arrangements ("HRAs").

The nature of the Proposed Rules

The proposed rule does not appear to provide complete and clear requirements for different SBCs within a single plan. For example, if a group health plan and/or health insurance issuer offers two versions of a Preferred-provider Health Plan Option ("PPO") with different contributions, deductibles and copayments, would it be required to provide two SBCs for the same plan?

Also, it is our recommendation that the final rule clarify whether premium and contribution costs are included within the SBC. WageWorks strongly believes that a simple, standard table that addresses premium costs, employee contributions and major provisions of the plan or plans would be the best way to provide information to participants in a manner that allows individuals and plan sponsors to easily compare the different plan options. Plan designs are so varied that a true apples-to-apples comparison is often difficult absent such a table.

In addition, further clarification is requested regarding the requirements that the SBC be presented in a "culturally and linguistically appropriate manner" and that the terms used in the SBC be limited so that an "average" enrollee can understand it. The definition of what constitutes an "average" enrollee needs to be expressly stated, and additional guidance is required on what level of differentiation is needed where the workforce is exceedingly diverse.

Further, WageWorks cautions that, with respect to the request for comment regarding coverage examples, coverage examples are ineffective unless those examples bear resemblance to the participant's own situation. Therefore, the challenge persists with limiting the number of coverage examples, beginning with three and eventually expanding to six, while also balancing the significant time and resources required to develop coverage examples for every imaginable scenario. Unless the coverage examples are consistent among each of the employer's plans, those examples will not provide the intended comparative tool for employees. The variables among plan design elements make it

inherently challenging to estimate costs and, additionally, the cost simulation can be significantly flawed because each scenario can be impacted by various elements outside of the limited scope of the scenario.

Duplication between required ERISA compliance and the newly created SBCs

The Proposed Rules do not appear to address the duplication of effort required specifically related to the ERISA requirement to provide a Summary Plan Description (“SPD”), or the possible exemption of employers that have taken the initiative to provide comparable information to employees regarding plan choices. While there is general agreement that SBC information can be contained within the SPD, such inclusion will likely create an overwhelmingly complicated document for an employee to review and comprehend, unless the entire document and components are written to the same standard of clarity and readability.

Delay of the effective date until the open enrollment period for the Plan Year that begins on or after one year following the date the final regulations are issued

March 23, 2012 is just only five months away. It will be almost impossible for employers to implement the required changes set forth in the Proposed Rules by March 2012, especially in light of the fact that final regulations have not yet been issued. Employers will need time to digest and identify the impacts that these new legal requirements will have on group health plans, enrollment procedures and administrative systems to ensure effective implementation of the rules. Accordingly, WageWorks respectfully requests that the implementation date be extended at least to the open enrollment period for the Plan Year that begins on or after one year following the date that the final regulations are released.

This delay is, in our opinion, supported by Section 2715, which provides no less than 12 months between the date the agencies develop the applicable standards and the implementation date.¹ Because final regulations have not been issued and the original effective date is only five months away, the delayed effective date is necessary and consistent with Congress' intent. Moreover, this proposed date is a natural transition point, since making the SBC rules effective prior to the annual enrollment period for the plan year beginning on or after the date that is one year after the final regulations are issued would otherwise require group health plan sponsors to create SBCs for any new and mid-year enrollments, but then require group health plan sponsors to quickly revise the SBCs to incorporate plan changes for the coming plan year.

Relaxation of electronic distribution requirements

The Proposed Rules indicate that SBCs furnished through electronic media (e.g., email, website, etc.) must satisfy ERISA's distribution requirements, which require plans to furnish notices required under

¹ See 2715(a) (“Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer.”)

ERISA by measures reasonably calculated to ensure actual receipt.² The Department of Labor has created a safe harbor for documents and materials furnished through electronic media.³ Under the safe harbor, recipients who are not otherwise expected to access the employer's electronic information system must provide advance electronic consent.⁴ Many enrollees will be required to provide advance consent; however, obtaining that consent will impose significant barriers for plans such that the requirement, if it is not waived, will prevent plans from furnishing SBCs electronically. This creates a substantial burden that fails to consider improvements in technologies that have increased access to electronic media (a possibility acknowledged by the Department of Labor in its request for comments on the ERISA electronic disclosure safe harbor)⁵ and alternative measures used with the electronic media that ensure actual receipt of the SBC—the fundamental standard under ERISA.

As an example, if a plan makes the SBCs available on a website, it would comply with the SBC disclosure requirements to the extent that the plan provides, at the time of enrollment, written notice of the right to request a copy. Under this approach, if the individual is not effectively able to access the electronic media, the participant is able to request a paper copy. As a result, this approach reasonably ensures actual receipt of the SBC consistent with ERISA's disclosure rules. This approach would also be consistent with current employee benefit plan related electronic disclosure rules under the Internal Revenue Code, which waive the consent requirement if the participant is effectively able to access the information⁶, and E-Sign legislation, which allows federal agencies to exempt disclosures from the consent requirement where such a requirement would impose a substantial burden on electronic commerce and exempting the disclosure will not increase the material risk of harm to recipients.⁷

Plans should be required to automatically furnish the SBC to “participants” only

Section 2715(d) requires group health plans and issuers to furnish SBCs to “enrollees”. The term “enrollees” is not defined in the statute but the Proposed Rules define “enrollee” to mean a “participant” or “beneficiary” as defined by ERISA. Beneficiaries (other than qualified beneficiaries under COBRA and perhaps survivors) typically have no right to enroll apart from the employee. Thus, if the employee chooses not to enroll the spouse or dependent child, the spouse or dependent child typically has no independent right to enroll. Although the SBC contains information that impacts a beneficiary's enrollment decisions for other plans, we note that other plan related documents required by law to be furnished by a plan, such as the summary plan description and the notice of the plan's special enrollment rights required by the HIPAA portability regulations,⁸ contain information that impact the spouse's enrollment decisions yet are not required to be provided furnished to the beneficiary. In those other situations, documents and materials required to be furnished to the participant are deemed to be provided to a spouse or other dependent. As a result, plans should not be required by the final regulations to furnish SBCs to beneficiaries unless requested by the beneficiary.

² See 29 C.F.R. 2520.104(b)-1. Under the Proposed Regulations, nonfederal governmental plans may furnish an SBC electronically in accordance with ERISA's disclosure rules or rules established in the Proposed Regulations for issuers in the individual market.

³ See 29 C.F.R. 2520.104(b)-1(c).

⁴ See 29 C.F.R. 2520.104(b)-1(c)(2).

⁵ See 76 Fed. Reg. 19285 (April 7, 2011).

⁶ See 26 C.F.R. 1.401(a)-20(c).

⁷ 17 U.S.C. 7004(d)(1).

⁸ 29 C.F.R. 2590.701-6(c).

Clarification of the application of the SBC to Health Reimbursement Arrangements

Finally, the application of PPACA to HRAs is unclear; particularly, whether the SBC and Proposed Rules apply. Many plan sponsors adopt and maintain HRAs—an employer-only funded defined contribution medical expense reimbursement account. There are typically two types of HRAs: an integrated “HRA” that is part of an underlying health plan and reimburses a portion of the out-of-pocket expenses incurred by the employee; and a “stand alone HRA,” which is a separate and distinct account made available to employees to assist them with their health care expenses or to purchase individual coverage. The SBC proposed rules create unique issues with respect to each type of HRA.

- **Integrated HRA**

Integrated HRAs are typically defined contribution arrangements with reimbursements limited to those expenses otherwise covered by the employer's major medical plan, but for a deductible, coinsurance or other financial limitation. Integrated HRAs are essentially supplemental plans that constitute part of the same benefit package option and that operate to reduce the plan's deductible or other out of pocket expense. In many cases, these HRAs are administered by an entity independent of the major medical plan administrator or health insurer.

Because integrated HRAs reduce financial limitations under the plan (e.g., the deductible) and are often administered by a separate entity, preparing the SBC for the benefit package option creates unique coordination issues between the HRA administrator and the health plan or health insurer. For example, the health plan may have a \$5,000 deductible; however, the employer also sponsors a self-insured HRA that will reimburse up to \$3,000 of the participant's “deductible” expenses each year. The health insurer and the HRA administrator must coordinate to identify the impact of the HRA on the plan's overall deductible. It isn't clear how this task would be accomplished. HRAs should be considered to be in compliance with the SBC proposed rules if the plan furnishes the participant with a summary plan description that satisfies the timing and content requirements set forth in ERISA (without regard to whether the plan is subject to ERISA).

If providing participants with a summary plan description that satisfies the timing and content requirements set forth in ERISA (without regard to whether the plan is subject to ERISA) is not acceptable, guidance on how the integrated HRA should be communicated in the SBC is required. For example, should the potential reimbursements simply be reflected in the plan's overall deductible and other financial limitation amounts identified in the SBC, or should the HRA reimbursements be identified separately? Either method seems to create confusion for participants.

- **Stand-alone HRA**

HRA is a simple arrangement by nature. Essentially, the employer agrees to reimburse eligible medical expenses, as defined by Internal Revenue Code Section 213(d), up to a specified annual maximum. The NAIC-proposed template does not, however, take into consideration this type of arrangement. Creating the SBC as set forth in the Proposed Rules will create an impossible administrative burden on HRA plan sponsors, and result in far more confusion for participants because it complements all other plans they have, acting as a contribution from the employer towards a participant’s out-of-pocket health care expenses under other plans. And, under these

arrangements, participants are typically enrolled automatically if they meet the eligibility requirements because, by definition, these are employer-funded arrangements, thus they do not need to make comparative decisions about an HRA. As a result, WageWorks requests that stand-alone HRAs be exempted from the SBC requirement to the extent that such HRAs are "health flexible spending arrangements," as defined by Internal Revenue Code Section 106(c).⁹

If such exclusion is not acceptable, HRAs should be deemed to be in compliance with the SBC rules if the plan furnished the participant with a summary plan description that satisfies the timing and content requirements set forth in ERISA (without regard to whether the plan is subject to ERISA).

Conclusion

In conclusion, WageWorks greatly appreciate the opportunity to provide comments and input on the Proposed Rules and looks forward to working collaboratively on subsequent PPACA regulatory action. If you have any questions about the comments above, please don't hesitate to contact me at 760.509.4656 or at jody.dietel@wageworks.com.

Sincerely,

Jody L. Dietel, CFCI, CAS
Chief Compliance Officer
WageWorks, Inc.

⁹ A "health flexible spending arrangement" as defined in Internal Revenue Code Section 106(c) is a plan or arrangement that reimburses specified expenses and the maximum reimbursement under the arrangement does not exceed 500% of the value of the coverage.