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October 21, 2011

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: Proposed Rules for the Summary of Benefits and Coverage and Uniform Glossary

To Whom It May Concern:

This letter is submitted by The Phia Group, LLC in response to the request for comments by the Employee Benefit Security Administration ("EBSA") regarding the proposed regulations and template for the Summary of Benefits and Coverage ("SBC") dated August 22, 2011, 76 Fed. Reg. 52475. In the proposed regulations EBSA has adopted the template developed by the National Association of Insurance Commissioners, a group that is comprised of state insurance regulators.

The Phia Group, LLC is a company specializing in cost containment strategies for the health care industry. The perspective we offer today is both as an employer offering a self-funded benefit plan to its employees and as a consultant working with many self-funded employers and third party administrators. Our attorneys have attempted to fill out an SBC for our employee benefit plan and were unable to complete the document because we could not fit the benefits, definitions, and exclusions as expressed in our plan within the rigid categories contained in the template proposed by EBSA.

As the template was created by NAIC whose membership deals with fully-insured plans, it does not take into account the unique differences between a self-funded and fully-insured plan. We feel that compliance with this template, as it currently is written, would be extremely problematic for self-funded employee benefit plans and would lead to more confusion amongst plan members.

Completion of this template will not fulfill the intent of this requirement in the Patient Protection and Affordable Care Act ("PPACA") which was to provide easy-to-understand information to plan participants.

Timing

- Regulations Release Date

  As initially required by PPACA, the agencies were required to release regulations pertaining to the Summary of Benefits and Coverage (SBC) by March 23, 2011. However, the agencies

did not publish the regulations until August 22, 2011. This delay of five months presents substantial harm for the benefit plans, insurers and third party administrators who must expend significant resources in a short amount of time to prepare this document in time for the March 23, 2012 deadline.

Further, upon release of regulations on August 22, 2011 the agencies provided that additional guidance and clarification was forthcoming. However, as of October 20, 2011 we are still awaiting that guidance. Thus, benefit plans, insurers and third party administrators are unable to craft a "complete draft" of the SBC since further information and guidance is required on the part of the agencies.

Even more, while there were no repercussions for the initial delay of the regulations by the agencies, the benefit plans, insurers and their third party administrators are still required and expected to complete the SBC as of the original deadlines.

A failure to adhere to the rules will result in significant fines and penalties. Benefit plans, insurers and third party administrators are now trying to coordinate efforts to craft the SBCs, but without further assistance and clarification from the agencies this is an impossible task.

- Advance Notice Requirements

The agencies require a 60-day advance notice of the proposed change that will affect the SBC. Even though this does not apply to renewals or reissuance of coverage, the impact of this requirement on benefit plans, insurers and third party administrators may be substantial. Thus, even if this requirement only applies for "only mid-year" changes, this is very restrictive.

It appears that the existing ERISA disclosure rules will continue to apply (i.e. the Summary of Material Modification (SMM)) being provided within 60 days). However, the agencies fail to identify how this requirement to provide this 60-day advance notice of any modification will affect the existing claims regulations which provide contrary regulations.

Terminology

- Terminology Is Specific to Fully Insured Plans and Not Applicable to Self-Funded Plans

As required by the agencies, certain terms must be included in the SBC, without any means to modify or customize the terms to suit the existing plan. This presents huge concerns and the potential for conflict and ambiguity.

A sampling of the problematic terms:

- Premium

  Per Merriam-Webster:

  Premium: The consideration paid for a contract of insurance.

  A self-funded plan is not insurance and is not a contract. This is a big discrepancy. With self-funding, employers make a contribution – and do not pay a premium – to a trust account from which claims are paid.

- Policy

  Per Collins, Collaborative Dictionary:

  Policy: An insurance policy is a document which shows the agreement that you have made with an insurance company.

  A self-funded plan is not insurance and is a plan for the employee, provided by the employer and NOT an insurance company.

- Allowed Amount

  This is a term that may already be defined in the insurance policy or plan document. Incorporating another definition to another separate document will create mass confusion. This will be particularly problematic should there be any issues as to what constitutes an "allowed amount."

  For example, the "allowed amount" may very well vary from the PPO Agreement, Plan Document and Summary Plan Description, Stop Loss Policy, and the Summary of Benefits and Coverage.

  In a situation when the terms vary greatly – which document will govern?

- Balance Billing

  The SBC references balance billing. This will be extremely problematic as this will not be uniformly applicable for all plans.

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For example, consider a Medicare patient. Balance billing is illegal for Medicare patients. It is also illegal in most states when the participant (with private insurance) seeks care from an in-network provider.

As written in the SBC, the concept of balance billing has not been accurately portrayed or considered – as it is not uniform for every claim or every participant.

In addition, the reference to balance billing may scare plan members into thinking that they will be balanced billed for all services provided by out-of-network providers. This may cause plan participants unnecessary stress and anxiety about paying for benefits.

Categories of services

- Benefits of Self-Funding Completely Overlooked

One of the benefits of establishing a self-funded plan is to customize the plan design to best and most appropriately suit the needs of the Plan Administrator.

In crafting a self-funded employee benefit plan, the Plan Administrator is granted the discretionary authority to have a customizable plan design. With this freedom the Plan Administrator for a self-funded plan is not required to categorize benefits within rigid categories. Plan Administrators have the flexibility to design their own benefit structure, including and categorizing benefits in a unique manner for the benefit of the participants. The SBC requirement to classify benefits into narrow categories presents a huge disadvantage for self-funded plans. These plans may not be able to fit their benefits into the categories presented on the SBC template.

Termination of coverage

- Ignorant of Self-Funded vs. Fully Insured Plans

Options provided for within the non-customizable template as prepared by NAIC, and adopted by the agencies, are specific only to fully insured plans.

As mentioned above, self-funded plans are unique in that they can customize their own plan design. The unique benefit structure or termination structure as set forth within a self-funded plan may not neatly fit into the pre-determined termination categories.

By being forced to fit within the specific categories, this will create confusion and inconsistency. For example, it is certainly possible that one of the termination provisions will not apply to a self-funded plan.

Requiring plans to incorporate inapplicable language within the SBC presents the opportunity for participants have conflicting information as to their rights of coverage. Thus, by being provided with the SBC participants will be even more confused about their options.

Coverage Examples

- Pregnancy, Diabetes, Cancer

As noted above, self-funded plans offer flexibility to design a benefit plan to meet the needs of the employees. This means that not all self-funded plans will cover the same services. Self-funded plans may choose to not cover services related to pregnancy, diabetes or cancer. For example only 46 states and the District of Columbia require coverage for diabetes, according to the National Conference of State Legislatures. (See www.ncsl.org/default.aspx?tabid=14504, last accessed on October 21, 2011.) Self-funded plans may not cover all of the categories of services listed within each coverage example. For example, many plans only cover hospital charges for the mother and not the newborn. Last, plans may have pre-authorization requirements and penalties for certain services, for example many plans do not offer automatic coverage for dependent children born to a plan participant and require notification of the intent to enroll within a specified time frame from the date of birth. How are requirements and limitations such as these expressed in the SBC?

Discretionary Authority

- Grant of Discretionary Authority

Noticeably absent from the draft template SBC document is any reference or indication to the Plan Administrator's grant of discretionary authority. Plan Administrators are granted discretionary authority to interpret the terms and provisions of the plan.

As this grant is important factor in determining benefits, discretionary authority should be addressed within the SBC document.

Summary of Benefits and Coverage (SBC) and Plan Document and Summary Plan Description (PD/SPD)

- SBC within the SPD/PD

The regulations leave many unanswered questions. One of the questions presented by others is whether the SBC may be provided as part of the SPD and/or PD.

The incorporation of the SBC with the SPD and/or PD would be problematic. The rules are still unclear as to exactly how the SBC must be drafted. Case law in many states and circuits hold that because the plan participants receive the SPD, they may base their understanding on

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the terms of the SPD and where the SPD contradicts the Plan Document, the SPD controls. Which document would control – the plan document, SBC, or SPD? There is a high likelihood that the information contained in the SBC template will conflict with the terms of the plan; a plan participant cannot reasonably compare plans if they are unable to ascertain the plan's benefits from the SBC because there is not any room for disclaimers, explanation, or alteration of the information in the SBC template.

Thank you for considering our comments. We hope our comments will be of use and reflected in the final rule. If you have any questions about our comments please contact The Phia Group at 781-535-5600.

Sincerely,

The Phia Group, LLC