January 6, 2012

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-9998-FC
PO Box 8010
Baltimore, MD 21244-8010

RE: File Code CMS-9998-FC (Medical Loss Ratio Requirements)

Dear Sir or Madam:

We are writing to you as organizations representing millions of American health care consumers, patients, and employees to thank you for keeping the medical loss ratio (MLR) interim final rule largely intact in the final rule published on December 7, 2011, and to provide our comments on certain provisions in the final rule. This final rule will play a very important and powerful role in assuring that consumers and businesses receive fair value for their premium dollar and help to assure the affordability and sustainability of health insurance for many Americans.

We were pleased to note and greatly appreciate the Department of Health and Human Service's (HHS) decision not to make any changes in the definition and treatment of agent and broker expenses. The final rule properly treats agent and broker expenses as administrative expenses, in accordance with the statutory language of the Patient Protection and Affordable Care Act (ACA) and as further defined through the thoughtful and careful work of the National Association of Insurance Commissioners (NAIC). We recognize that agents and brokers have played a significant role in advising consumers and employers on the purchase of health insurance and in servicing policies, but this is clearly an administrative cost. Thus we strongly support the treatment of agent and broker expenses as administrative costs.

A. "Mini-med" Policies

The final rule phases down the multiplier adjustment that will be applied to mini-med policies for the 2012 through 2014 MLR reporting years. Beginning in 2015, no adjustment will be in order for these plans. We believe HHS is moving in the right direction in reducing the multiplier, and we support the elimination of the multiplier in 2015 and beyond when consumers will have access to better, more affordable insurance options. It is difficult to assess whether the multipliers being adopted for 2012, 2013, and 2014 are set at the appropriate level – or even whether they are necessary at all -- without having the opportunity to review the data that mini-med issuers submitted this year. We urge HHS to make this data publicly available as soon as possible, in accordance with the statute.

Meanwhile, while we recognize that for some consumers these types of policies may be all they can afford until 2014 and therefore should continue to be available, based on the information made available in the preface to the rule, we see no reason not to move to a multiplier of 1.5 for issuers in the small and large group markets for 2012. We also question based on that information whether it would not be possible to move immediately to 1.5 for the individual

market, given that the number of enrollees receiving rebates would increase from about 43,500 to 62,700 and the amount of rebates would only increase from $1.1 million to $5 million (as compared to 176,000 enrollees receiving an estimated $53 million in rebates if the multiplier were reduced to 1). HHS should also consider moving to 1.25 for 2013, rather than waiting until 2014.

B. "Expatriate Policies"

As with mini-med policies, we find it difficult to assess whether the special treatment afforded to expatriate policies under the final rule is warranted without having access to the data on which this decision is based. We encourage HHS to also make this data available to the public as soon as possible.

C. Fraud Reduction Expenses

We applaud HHS's decision to continue excluding fraud prevention and recovery activities from the definition of quality improvement activities (QIA). In particular, HHS noted in its explanation for this decision that the "current treatment of fraud reductions efforts under the MLR rule is consistent with the NAIC's position and adequately addresses the concerns of issuers…" We, too, believe the current treatment of fraud reduction expenses strikes a fair and reasonable balance in accounting for these expenses by allowing payments recovered through fraud reduction efforts to be treated as adjustments to incurred claims, rather than considering them to be part of QIA. This approach helps to maintain the integrity of the MLR formula.

D. ICD-10 Conversion Expenses

As requested, our comments focus on the treatment of ICD-10 conversion expenses and specifically on whether including these costs as a QIA expense is appropriate, and if some portion of these costs is considered a QIA, whether the cap of 0.3 percent for years 2012 and 2013 is reasonable.

Appropriateness of Treatment of ICD-10 Expenses

Our organizations continue to believe that ICD-10 conversion costs are an administrative expense, and it is not appropriate to consider these expenses as a QIA. Claims processing is a core administrative competency and a key component of an insurance product. Conversion to a world standard data coding classification system does not make this activity a QIA as defined in the ACA or the MLR definition.

We acknowledge that the ICD-10 conversion process can, as stated by a health insurance issuer in the preamble of the final rule, "improve health plans' ability to share data among clinicians for the purpose of quality improvement and care coordination activities, thereby allowing for a better understanding of diagnoses and better treatment." However, the data coding classification system in and of itself only provides the infrastructure to more accurately code the delivery of care and facilitate appropriate and accurate claims payment. Other initiatives are required to analyze or measure health outcomes, such as the activities contained in the current QIA definition. This

position is further supported by the comments submitted by the provider associations who "contended that ICD-10 does not have any bearing on the treatment that an enrollee receives and that there is no direct impact on patient outcomes, even if it benefits the medical community as a whole." In conclusion, the ICD-10 conversion process is a core administrative function or at best, a quality *assurance* (not quality *improvement*) data coding activity, expected of an insurer to provide a viable and competitive product in the marketplace and should not be treated as a QIA expense.

We do support the final rule's acknowledgement that ICD-10 maintenance costs are administrative expenses and therefore excluded from QIA.

Level of Cap on ICD-10 Expenses

In the event that HHS chooses not to follow our recommendation to classify all ICD-10 expenses as administrative costs, than we propose a lower cap on those expenses that can be counted as QIA, as follows. The final rule limits the amount of ICD-10 conversion expenses that may count as QIA to 0.3% of an issuer's earned premiums in 2012 and 2013. We strongly support the two-year limit and propose lowering the proposed cap of 0.3% to a more reasonable percentage that is based on pro-rating the amount of ICD-10 conversion expenses that CMS considers to be related to quality.

More specifically, we recommend only allowing up to 40% of the total 2012 and 2013 ICD-10 conversion expenses to be counted as QIA expenses, and the premium cap should be modified accordingly. This recommendation is based on the testimony of Ms. Denise M. Buenning, Director of the Administrative Simplification Group, Office of E-Health Standards and Services, Centers for Medicare & Medicaid Services, in her remarks on November 2, 2011 before the NAIC's MLR Quality Improvement Activities (B) Subgroup meeting. Ms. Buenning indicated that CMS considered approximately 40% of the ICD-10 conversion costs to be quality-related, while the majority of the costs are administrative.

It is difficult to know exactly what data and assumptions CMS used in arriving at the 0.3% cap, but it appears that the level of the cap may allow insurers to claim much more than 40% of their conversion expenses – and potentially up to 100% of their ICD-10 conversion expenses – as QIA. While 0.3% seems like a small amount, this level is 10 times higher than what health insurers spent for ICD-10 conversion in 2010. According to an industry study of 20 health insurance plans, ICD-10 conversion "costs averaged about $12 per member, with small health plans paying around $38 per member and large health plans paying around $11 per member." These costs are significantly less than 0.3% of an issuer's earned premiums.

Moreover, if HHS does allow a portion of the ICD-10 conversion costs to be included as QIA expenses in 2012 and 2013, then all issuers should be required to use a standardized accounting methodology to justify the allowable portion of the ICD-10 conversion costs or the costs should not be allowed as QIA expenses. These expenses should also be identifiable in the Supplemental Health Care Exhibit (SHCE) to determine if they are reasonable and comparable to similar-sized insurers.

We also recommend adding language to affirm that ICD-10 conversion costs are to be proportioned across all of the issuer's products that employ ICD-10 coding in the claims adjudication process. Other products include, but are not limited to, ERISA self-funded plans, worker's compensation, Medicare, and Medicaid so that only the appropriate proportion of ICD-10 conversion expenses is allocated to insured products subject to the ACA's MLR requirements.

We also believe the phrase in §158.150(6) – "that are designed to improve quality" – is too broad and should be narrowly crafted to reflect the fact that the ICD-10 conversion costs are an administrative claims data coding expense that is being allowed as a one-time exception. As written, the phrase may be interpreted to include activities that do not involve the delivery of health care and could set a serious precedent that may undermine the careful intent of the definition of health care quality activities used to document expenses in the MLR and other federal and state forms used to account for health insurance premium expenditures under the ACA.

E. Community Benefit Expenditures

We are concerned about the modifications that the final rule makes to the way that community benefit expenditures may be considered in an issuer's MLR calculation. Allowing for-profit insurers the option of excluding community benefit expenditures from their premium revenue totals in excess of what they actually pay in taxes exceeds HHS's authority under the statute and violates the Congressional intent to exclude only the federal and state taxes that a carrier pays.

Section 2718 of the Affordable Care Act permits the removal of "Federal and State taxes and licensing or regulatory fees" from an insurer's premium revenue total in its MLR calculation. The members of Congress responsible for drafting this MLR provision clarified that their true intent was to only exclude those taxes and fees related to the provision of health insurance referenced in the Affordable Care Act.[1] The interim final rule went beyond this intent by allowing the exclusion of all federal and state taxes from premium calculations, along with the exclusion of community benefit payments made by not-for-profit issuers. The statute does not provide for the removal of community benefit expenditures from premium revenues for any carriers.

We understand that in the interim final rule HHS wanted to level the playing field for not-for-profit insurers, which frequently do not pay taxes, and therefore allowed them to exclude community benefit expenditures up to a limit of what they would pay in taxes if they were for-profit carriers. However, the final rule now allows all carriers, including for-profit insurers, to choose to exclude either their community benefit expenditures "up to the highest premium tax rate in the State" or their federal and state taxes, whichever is greater. This provision may represent a significant step to reduce carriers' reported premium revenues and could thereby undermine the effectiveness of the MLR as a protection for consumers, particularly if they are customers of for-profit insurers.
This new allowance for for-profit carriers complicates a straightforward statutory category – taxes paid – by allowing the substitution of a variety of other expenses which have historically

[1] Senator Max Baucus, Senator Sander Levin, et. al. *Letter to Secretary Kathleen Sebelius* (Washington: United States Congress, August 10, 2010).

been difficult to measure. The preamble states that issuers themselves expressed that "not-for-profit issuers have fundamentally different missions than for-profit issuers." We agree and think this change is unmerited. The preamble does not articulate to what extent for-profit insurers actually engage in community benefit spending, and no estimates are included of the extent to which for-profit insurers will now exclude costs up to the highest tax rate in the state, regardless of whether they are subject to that tax rate.

Moreover, the definition of community benefits that is in the final rule is not adequate and does not provide a standard that can be monitored when applied to for-profit insurers. When a non-profit carrier provides community benefits in lieu of taxes, states often have agreements about exactly what benefits the carrier will provide that are sufficient to warrant a waiver of premium tax liability. If contrary to our strong recommendation, HHS moves away from the concept that community benefits can only be excluded from the MLR calculation to the extent that taxes would otherwise be excluded, HHS must provide a much stronger and narrower definition of community benefits and must designate either the state or the federal government to monitor whether the carrier is actually providing benefits beyond what would be normal in its course of business. In particular, §158.162(3) allows a carrier to count activities that "advance health care knowledge though education" as community benefits. This definition must be strengthened to prevent carriers from counting their normal marketing activities and member newsletters (which often double as marketing materials) as a community benefit. A federal or state regulator and public health entity should determine that the activities that a carrier proposes to count as community benefits contribute to needed public health or health care programming that goes beyond the carrier's normal activities.

The preamble recognizes that the effect of the modification to community benefit exclusions in the final rule is that "rebates may be reduced for issuers in states with a higher maximum premium tax rate than they are required to pay." This result represents a decrease in value for consumers. A recent study by the Government Accountability Office documents that carriers are generally able to meet the MLR standards already.[2] Despite this evidence, the final rule proposes to make it easier for carriers to meet the MLR standards without increasing value to consumers.

We urge HHS to reconsider allowing for-profit insurers to exclude community benefit expenditures from premium revenues. Including only actual tax and regulatory fees will ensure that for-profit insurers, which are businesses and not benevolent institutions, are held accountable to consumers.

F. Rebates to Enrollees in Group Markets

Payment of Rebates

We have some concerns about the modification in the final rule that eliminates insurers' responsibility for ensuring that subscribers in group plans receive rebates in proportion to the share of premiums that they contributed for coverage. As the preamble recognizes, the statute "directs that enrollees receive the benefit of rebates." We therefore want to ensure that sufficient

[2] Government Accountability Office, *Early Indicators Show That Most Insurers Would Have Met or Exceeded New Medical Loss Ratio Standards* (Washington, GAO, October 31, 2011).

safeguards are in place to guarantee that rebates paid to policyholders are in fact used to benefit enrollees in proportion to at least the share of premiums that they contributed.

Under the final rule, group plans that are not subject to ERISA and are not governmental plans must provide written assurance to issuers that any rebates received by the policyholder will be used for the benefit of subscribers using one of the prescribed options that are to be outlined in regulation. If an issuer does not receive this assurance from such a plan, the issuer must pay the subscribers of the plan the total amount of the rebate, divided across all subscribers. We support this provision and recommend that HHS consider adopting this model for all group plans, as it provides a greater guarantee that plan enrollees will receive the benefits of their share of rebates, as required under the statute.

When policyholders provide written assurance to issuers that rebates will be used to the benefit of subscribers, we recommend that a copy of this assurance be delivered to the subscribers, in conjunction with the notices required under §158.250, so that their rights are made transparent to them. This written assurance should detail how policyholders will use the rebate to benefit subscribers. In addition, the final rule does not clarify that in this written assurance the policyholder must state that subscribers will benefit from rebates *in proportion to at least the amount that subscribers contributed towards the premiums.* We therefore request that HHS add this detail to §158.242 of the final rule. For all group plans, the regulation should clarify that rebates must be used to the benefit of subscribers *in proportion to at least the amount that subscribers contributed towards the premiums.*

The final rule refers to a listing of methods that policyholders can use to apply rebates to the benefit of subscribers. However, the section referred to for this, §158.242(b)(1), is currently "Reserved." We urge HHS to clarify that rebates should be used to lower subscribers' health coverage costs. We also believe that a public comment period should be provided on the options that HHS provides for the use of rebates in group plans since these options are not currently included in the final rule and therefore are not available for comment.

We further recommend that the final rule clarify how HHS will ensure that policyholders follow through with their obligations to use rebates to the benefit of subscribers in proportion to at least the amount that subscribers contributed towards premiums. We recommend that subscribers receive notice of contact numbers at HHS and the Department of Labor that they can use to seek help if they believe that rebates in their group plan are not being used to their benefit in accordance with the law. This information should be included in the notice required under §158.250.

We support the requirement that if any type of group health plan has been terminated at the time of rebate payment and the issuer cannot, despite reasonable efforts, locate the policyholder, the issuer must distribute the entire rebate to the subscribers of the group health plan enrolled during the relevant MLR reporting year by dividing it equally among all of the subscribers entitled to a rebate. We also strongly support the modification to the minimum threshold for issuer payments of rebates in the group market from $5.00 per subscriber to a total of $20.00 for the policyholder and all subscriber portions of the rebate when the rebate is paid directly to the policyholder. This

modification will provide greater value in health coverage to employers and health plan enrollees.

Also, in §158.244, HHS should provide specific language as to what constitutes a "good faith effort" to locate and deliver required rebates. Issuers should be required to report the share of rebate dollars that were not claimed in any given year. This information should be reported to HHS and HHS should publish it on its website.

Notice of Rebates

Consumer groups applaud the updated notice requirement that will ensure consumers and employers receive information on the amount of their rebate and their insurer's MLR. Such notices are essential to ensuring that consumers and employers understand the purpose and origin of their MLR rebates. We recommend strengthening the rule to remove ambiguity in several areas:

When the notice must be provided: The final rule proposes a new notice requirement that would, according to the HHS Fact Sheet about it, "ensure all consumers receive information on either the amount of their rebate or their insurer's MLR, regardless of whether there is a rebate, as well as how the insurer's MLR has improved under the new law." The preamble to the rule notes that "transparency is a way to educate consumers and promote informed decision-making in the purchasing of health insurance." We strongly support the expansion of the current notice requirements to enrollees and policyholders who are not owed rebates and urge HHS to finalize this requirement, along with the additional recommendations below.

We recommend expanding the notice requirement so that *every* enrollee in a fully-insured product receives a notice of their plan's MLR, along with a description (as described below). Enrollees who are due rebates would receive a longer version of the notice, explaining the rebate.

A regular, annual communication would accomplish several things.

(1) Consumers can begin to learn about this dimension of their health plan via a well-crafted notice. If these communications are made infrequently to only a handful of consumers, the goal of increased transparency will not be accomplished.
(2) If the goal of informed decision making is to be realized, consumers must be able to connect strong MLRs with the correct health plans. Clear notices, in conjunction with the posting of plan MLR data on the HHS website (as required by Section 2718(a) of the ACA), are essential to achieving that end.

A voluntary approach, whereby issuers who do not have to provide a rebate are allowed, but not required, to provide notice, is not workable. To receive such notices in a seemingly random fashion sows confusion with consumers and does not create the ubiquitous presence needed to create new expectations among consumers.

Information to be included in the notice for individual subscribers: The final rule includes a short list of information to be included when notices are provided to subscribers in the individual

market. We recommend this list be augmented as indicated by the language below (new language being recommended in italics). Items (1) – (6) and (10) are to be provided to all consumers. Consumers receiving a rebate would also receive information in items (7) – (9).

(1) A general description of the concept of an MLR;
(2) The purpose of setting a MLR standard *and why it is important to consumers*;
(3) The applicable MLR standard;
(4) The issuer's MLR, adjusted in accordance with the provisions of this subpart;
(5) *A clear statement as to whether or not the consumer/employer must take any action.*
(6) The issuer's aggregate premium revenue as reported in accordance with § 158.130, minus any Federal and State taxes and licensing and regulatory fees that may be excluded from premium revenue as described in §§ 158.161(a) and 158.162(a)(1) and (b)(1);
(7) The rebate percentage and amount owed to enrollees based upon the difference between the issuer's MLR and the applicable MLR standard;
(8) *Information on how the rebate will be issued (reduction in a premium owed, lump-sum check, or, lump-sum reimbursement to the credit card or debit that the enrollee used to pay the premium). This information must include a method the consumer can use for remedy if the plan's chosen method is not practicable, e.g., the credit card account is now closed*.
(9) *A statement making it clear that the consumer's own funds are being returned, and the rebate is not a benevolent act by the insurer.* (Merely referring to the law, as described above, is insufficient);
(10) *Health plan phone number for the consumer to call if he or she has questions; as well as the state health insurance department's consumer assistance line in case the health plan is not responsive.*

Information to be included in the notice for policyholders and group plan subscribers: The final rule includes a short list of information to be included when notices are provided to policyholders and subscribers in the group market. We recommend this list be augmented as indicated by the language below (new language being recommended in italics). Items (1) – (6) and (10) are to be provided to all subscribers and policyholders. Group plans owing rebates would also have to provide the information in items (7) – (9) and (11)-(12).

(1) A general description of the concept of an MLR;
(2) The purpose of setting a MLR standard *and why it is important to consumers/employers*;
(3) The applicable MLR standard;
(4) The issuer's MLR, adjusted in accordance with the provisions of this subpart;
(5) *A clear statement as to whether or not the consumer/employer must take any action.*
(6) The issuer's aggregate premium revenue as reported in accordance with § 158.130, minus any Federal and State taxes and licensing and regulatory fees that may be excluded from premium revenue as described in §§ 158.161(a) and 158.162(a)(1) and (b)(1);
(7) The rebate percentage and amount owed to enrollees based upon the difference between the issuer's MLR and the applicable MLR standard *and a statement that plan enrollees are entitled to the benefits of the rebate in proportion to at least the amount that they contributed towards the premiums;*

(8) *Information on the method through which subscribers will receive the benefit of the rebate delivered to the policyholder in proportion to at least the share of premiums they contributed;*
(9) *A statement making it clear that the consumer's and employer's own funds are being returned, and the rebate is not a benevolent act by the insurer.* (Merely referring to the law, as described above, is insufficient);
(10) *Health plan phone number for the consumer/employer to call if he or she has questions; as well as the state health insurance department's consumer assistance line and the Department of Labor Employee Benefits Security Administration's consumer hotline in case the health plan is not responsive;*
(11) The fact that, as provided by this subpart, the total aggregated rebate for the group health plan is being provided to the policyholder *and:*

(i) the proportion of the rebate attributable to subscribers' contributions to premiums must be used for the benefit of subscribers, using one of the methods set forth in §158.242(b)(1) of this subpart and detailed in the notice;
(ii) The policyholder has provided written assurance that the proportion of the rebate attributable to subscribers' contribution to premium will be used for the benefit of current subscribers, using one of the methods set forth in §158.242(b)(1) of this subpart, or if the policyholder did not provide such written assurance, the issuer must distribute the rebate evenly among the policyholder's subscribers covered by the policy during the MLR reporting year on which the rebate is based;
(iii) If the policy provides benefits for a plan subject to ERISA, a statement that the policyholder may have additional obligations under ERISA's fiduciary responsibility provisions with respect to the handling of rebates and contact information for questions regarding the rebate;

(12) *Employer guidance on the methods through which the rebate must be distributed to employees at least in proportion to the share of premium enrollees contributed*.

Our suggested modifications under number (11) above reflect our recommendations for strengthening section §158.242 to ensure that group plan enrollees receive the benefits of rebates provided to policyholders as required under the law, in accordance with their share of premium payments. Specifically, all group plan policyholders should be required to provide written assurance that they will use rebates to benefit enrollees, and notices should reflect this not just for group health plans that are non-governmental, non-ERISA plans, but for all group plans. Additionally, for all group plans, the regulation should clarify that rebates must be used to the benefit of subscribers *in proportion to at least the amount that subscribers contributed towards the premiums,* and notices should reflect this for *all* group plans, including those subject to ERISA.

MLR information and consumer plan selection: When the explanatory material discusses how a MLR should be taken into account when purchasing a health plan, then the timing issues associated with the MLR must be made clear. For example, the MLR notice consumers receive in 2012 will refer to MLRs realized in 2011, but the next time the consumer shops for a plan, he or she will be seeking coverage for 2013. The 2012 MLR notice might have very little to do with the consumer's choices during the next open enrollment period.

However, as proposed in the preamble, consumers may be interested in seeing the two most recent MLR reports for a carrier in the notices they receive so that they can "see whether the issuer is doing a better or worse job than the year before of efficiently using premium revenue." We support the adoption of this proposal, which, along with the posting of MLR information on the HHS website as required under Section 2718(a) of the statute, will help consumers better use MLR information when making plan choices.

Other requirements for the notice: In the rule, HHS indicates that in the near future, HHS will publish the model disclosure language and will solicit public comment. We strongly recommend including the following additional requirements to ensure that the notice is understandable to consumers:

- The notice must be written in a consumer-friendly fashion. Plain language should be used and legal references and jargon minimized.
- The initial information should be the information of greatest interest to the consumer. For example, for rebate recipients, the key information is likely to be the amount of the rebate, the form of the rebate, any action the consumer or employer needs to take to get the rebate and a short explanation as to why. The legal references and the calculation of the rebate should be visually separated from this primary information.
- It must be immediately apparent why it is important for the recipient to read the notice. The envelope should include a designation of "important" or "rebate information enclosed" so that it is not tossed aside. The envelope should also include instructions for contacting the issuer if the addressee is no longer at the address.
- Notices should be provided in the primary language spoken by the consumer.

These final two requirements should be coordinated with an enhanced definition of "good faith effort" as used in §158.244.

HHS should consumer-test the draft model notice.

Timing of notice: In the preamble of the rule, it states that the rebate notification must accompany the rebate check or be sent at the same time as the premium credit is applied. However, the actual rule is more ambiguous, stating that the notice be provided "at the time any rebate of premium is provided." We recommend greater specificity here. The timing should depend on form the rebate will take:

- If there is no rebate (only a notice of the plan's MLR), then the timing should be the same general timing as rebate notices.
- If the rebate is in the form of a check, the notice should accompany the check.
- If the rebate is in the form of a credit to the consumer's credit card or debit card, the notice should *precede* the rebate in case those accounts are no longer active. Consumers must be given an opportunity to redirect the rebate.
- If the rebate is in the form of a premium credit, the notice should *precede* the rebate in case the consumer has no plans to re-enroll in that health plan. Consumers must be given an opportunity to redirect the rebate.

Prospective Notices for Mini-Med Plans

The preamble to the interim final rule notes that "transparency is a way to educate consumers and promote informed decision-making in the purchasing of health insurance." This is a laudable goal, but in order to promote informed decision making, MLR information provided to consumers must be structured so as to be forward looking, not solely retrospective.

A critical area for a prospective notice is prior to the sale of mini-med health plans. These health plans are subject to a much lower MLR threshold, a fact that consumers must be made aware of *prior* to the purchase of such plans, not at the time of rebate payments.

We recommend an additional notice requirement that uses the consumer-friendly features as described above (plain language, etc.), but is provided to consumers and employers prior to the purchase of a mini-med health plan. Indeed, such plans already face a notice requirement: the notice advising purchasers of the plan's waiver from the ACA's annual benefit limit rules.[3] More specifically, the Annual Benefit Limit Notice incorporates these requirements:

- shall be prominently displayed in clear, conspicuous 14 point bold type on the front of the materials.
- the notice must be provided to current and eligible participants and subscribers within 60 days from the date of issuance of this guidance. … [T]he notice must be provided to eligible participants and subscribers as part of any informational or educational materials, and also in any plan or policy documents evidencing coverage that are sent to enrollees (e.g., summary plan descriptions).

We recommend augmenting these requirements to reflect the MLR adjustments allowed to mini-med plans and strengthening the requirements as follows:

- Add new language that explains, in a consumer-friendly fashion, that the plan is also subject to less rigorous MLR standards.
- Make it clear that the revised notice must be provided to consumers/employers at the point at which they are shopping for a health plan, perhaps at the same time the Summary of Benefits and Coverage is provided.

G. Other Issues

Finally, although this wasn't addressed in the final rule, we continue to recommend that §158.170 of the rule be strengthened to require insurers to follow a single, consistent approach to classifying expenditures in order to prevent manipulation of the classification of expenses in a manner that artificially inflates medical loss ratios.

[3] http://www.healthcare.gov/law/resources/regulations/guidance-limited-benefit-2nd-supp-bulletin-120910.pdf

Thank you for your consideration of our comments and recommendations.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Federation of State, County and Municipal Employees (AFSCME)
Brain Injury Association of America
Colorado Consumer Health Initiative
Consumers for Affordable Health Care
Consumers Union
Families USA
Health Care for America Now
National Partnership for Women and Families
National Women's Law Center
SEIU

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