

December 17, 2010

Honorable Kathleen Sebelius
Secretary
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Honorable Hilda Solis
Secretary
US Department of Labor
200 Constitution Avenue, NW
Washington DC 20210

Dear Secretary Sebelius and Secretary Solis:

We are pleased to provide you standard definitions and standards for the summary of benefits and coverage for your review and consideration. These documents (enclosed) are the product of the Consumer Information (B) Subgroup established by the National Association of Insurance Commissioners (NAIC), pursuant to §1001 (adding § 2715 to the Public Health Service Act) of the Patient Protection and Affordable Care Act (PPACA).

The PPACA requires a consultation with the NAIC and a working group composed of health care professionals, patient advocates and other qualified individuals. The NAIC appointed a “group composed of representatives of health insurance-related, consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.” The NAIC created the Consumer Information (B) Subgroup and appointed a diverse membership, bringing together individuals representing the interests and expertise you requested. A complete list of the Subgroup’s membership is enclosed for your reference.

The Subgroup met for over 120 hours. The Subgroup created two teams, one focused on standard definitions and the other on the standards for the summary of benefits and coverage. Both teams met, in person or by conference call, more than 25 times. Each meeting and conference call lasted for 2 to 6 hours. Each was open to other interested individuals and parties and provided opportunity for comment and feedback from non-members. Each call had approximately 100 people participating, which is relatively high compared to most NAIC-related work. This demonstrates a high interest and involvement from a broad range of interested parties from around the nation. Members of the Subgroup, representing different perspectives, were appointed as “leads” to develop definitions, the explanation of coverage document, and instructions. Drafts were then fully discussed by the Subgroup team, revised, and further refined. Many changes were made in response to feedback from non-Subgroup members throughout the process.

The Subgroup sought to create consumer friendly and linguistically and culturally appropriate definitions for each of the statutorily dictated terms and also developed definitions for other terms the Subgroup deemed important for consumer understanding of the summary of benefits and coverage documents. These definitions are designed to meet the “plain language” requirement of the law that will aid the understanding of consumers.

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To gain a better understanding of both "plain language" and "linguistically and culturally appropriate" statutory requirements, the Subgroup held hearings to receive expert testimony on both issues. Members of the Subgroup representing ethnic minority constituencies with relatively high rates of limited English proficiency (LEP) testified, providing recommendations on how to create tools and materials that will serve diverse communities. Their presentations underscored that consumer-centered information is not "one size fits all" and that cultural and language backgrounds influence one's understanding and must be considered in translation. They strongly advised that testing and assessment be done in consultation with representative consumer organizations. Due to resource and time constraints, translations and further consumer group testing by the Subgroup was not an option. Federal regulators should consider providing translated and culturally appropriate material that, where feasible, has been developed through focus group testing.

Most of the definitions were reviewed by individuals who are expert in the areas of consumer communication and comprehension. Additionally, consumer testing, with a number of focus groups was performed by two separate organizations: Consumers Union and America's Health Insurance Plans (AHIP). We will make both reports available to you. The summary of coverage form and glossary documents were revisited and revised based on the feedback from consumer testing. Some revisions were also made based on feedback through the public comment period. Additionally, insurers tested the forms, throughout the process, to understand the functionality of the documents.

In developing the standards for the summary of benefits and coverage, the Subgroup sought to provide information to assist consumers in understanding the complex world of health care financing and delivery. This provides important information needed in order to make informed buying decisions. By necessity, the summary of benefits and coverage lacks some of the detail found in the health insurance policy or certificate and, in some sections, the standards for the summary of benefits and coverage refers the consumer to the health insurance policy or certificate for more information. We have attached some sample insurance contract language, as an addendum to this letter, to highlight the differences in the language and approach. For self-insured plans, consumers only receive a summary of benefits and coverage and may go to their employer to obtain more detailed information about their plan.

We recognize the law requires inclusion of a statement of whether the plan provides minimum essential coverage and covers at least 60% of total allowed costs of benefits (bronze level). Since standards for essential health benefit coverage have not yet been established by the Secretary, the Subgroup's recommendation does not include such a statement in the coverage summary at this time. The Subgroup recommends that insurers be required to include such a statement (developed by the Subgroup) on and after January 1, 2014, when qualified health plans must meet these essential health benefit requirements.

The summary of benefits and coverage document is intended to be a freestanding document. Insurers will complete the document for their benefit plans in accordance with the requirements of PPACA. The form is intended to be used for individual, small and large group insurers. We have developed one set of instructions for individually purchased and non-group policies and another set for all group insurance products. There may be additional changes required to the forms and instructions for large self-funded employer plans and for HMOs, but those changes have not yet been formulated in the attached documents.

As supplementary standardized documents, these are not designed to preempt stricter state requirements that apply to benefit summaries and insurance contracts. Further, we are assuming that states will be permitted, through your rule issuance process, to promulgate additional requirements for health insurance issuers if a state determines it is in the best interests of its residents. States understand that they may add requirements not precluded by federal law.

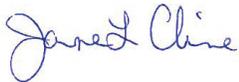
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While these recommendations address key deliverables set forth in the law, we expect to provide additional recommendations. The Subgroup in its on-going and future work will consider the design and content of the Coverage Facts, additional definitions, and standard enrollment application for exchanges. The Subgroup is fully committed to continue discussions with your team to develop a workable approach for the coverage facts label that promotes transparency and empowers consumers to make more informed decisions about their coverage options.

In addition, we recognize that it is likely that future opportunities to improve the summary and instructions will be identified once the final documents are implemented and put into practice for thousands of insurance policy forms and for millions of consumers. We anticipate that changes could improve the documents' usefulness for consumers and the need for additional instructions to help insurers more accurately complete the forms. Because the Subgroup has gained extensive experience during the development of these documents, we believe we are uniquely qualified to consider and facilitate future changes to the summary of benefits and coverage, as well as to the instructions. We propose that the Subgroup be utilized to monitor issues identified by consumers, carriers, and employer health plans, as these documents are implemented. Further, we recommend that upon review and discussion of these issues, the Subgroup may propose needed modifications or clarifications to the documents for your consideration.

We thank you for the opportunity to collaborate with you on this important project and look forward to a continued dialogue as you continue to establish the groundwork for the full implementation of PPACA.

Sincerely,



Jane Cline
NAIC President
West Virginia Insurance Commissioner



Susan Voss
NAIC President-Elect
Iowa Insurance Commissioner



Kevin McCarty
NAIC Vice-President
Florida Insurance Commissioner



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