America's Health
Insurance Plans

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March 2, 2012

Attention: Document Identifier: CMS – 10418
Centers for Medicare & Medicaid Services (CMS)
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Room C4–26–05
7500 Security Boulevard
Baltimore, Maryland 21244–1850

Subject: **Information Collection Request**
Medical Loss Ratio (MLR) Model Rebate Notices
Document Identifier/Form Number: CMS–10418 (OCN 0938 – NEW)

Submitted via www.regulations.gov

Dear Sir or Madam:

We provide these comments in response to the Information Collection Request (ICR) published in the Federal Register on February 21, 2012 (77 FR 9931). The ICR requests comments on the form of the notices of rebate ("Rebate Notices" or "Sample Forms 1, 2, and 3") based on the Medical Loss Ratio (MLR) requirements under Section 2718 of the Affordable Care Act (ACA). The ICR also includes instructions for a proposed model for notice of MLR to non-recipients of rebates ("Notice of MLR Information" or "Sample Form 4").

AHIP and its members (1) oppose any requirement for a Notice of MLR Information to non-recipients of rebates as such a requirement is contrary to Congressional intent and applicable Executive Order, has no utility for someone not receiving a rebate, is needless paperwork, adds administrative costs, and would potentially create significant confusion for consumers; and (2) offer suggestions below to the Rebate Notices to give health plans flexibility to produce notices that include the information required by §158.250 by using language that is understandable to consumers since testing that has been done indicates that the notices do not meet readability indices.

We ask for prompt action to resolve these issues as soon as possible so as to allow for operational changes to begin in compliance with the distribution of rebates.

Notice of MLR Information to Non-Recipients of Rebates

The instructions and the sample Notice of MLR Information to non-recipients of rebates raise significant concerns for health plans. AHIP raised many of these same concerns in our comments to the MLR Final Rule published in the Federal Register on December 7, 2011.[1] The comments on this issue focused on the confusion and unintended consequences of any new requirement that add unnecessary administrative costs and complexity to a process for MLR calculations and reporting that is already onerous. In addition, our comments described why the agency's justification for requiring these Notices – as a predictor of year-to-year premiums or MLRs – is flawed because of the year-to-year variation based on claims, adjustments, and premiums, as well as cumulative credibility calculations.

Recommendation: We continue to strongly oppose the Notice of MLR Information to non-recipients of rebates proposal as it is contrary to Congressional intent and is duplicative, unnecessary, costly and confusing. Additionally, requiring such a notice would add administrative burden and costs on health plans and policyholders that is not justified - the significant costs clearly outweigh any benefit. We urge that it not be included as a final requirement.

Below are our specific objections to the Notice of MLR Information proposal for non-recipients of rebates:

1. **Section 2718 does not require health plans to distribute notices to those who are enrolled in plans that have met the MLR threshold ("Notice of MLR Information"). Such a requirement is contrary to Congressional intent.**

Congress made an express choice to provide MLR information to consumers through the Secretary and the web portal. As currently described, the Notice of MLR Information for non-recipients of rebates repeats or is drawn entirely from information that the health plans must submit to the agency pursuant to PHSA § 2718(a) as line items in the annual reports to the Secretary, and that the agency itself is statutorily charged with making available to consumers. Forcing health plans to provide personalized and expensive mailed notice of that same information to each non-rebate policyholder or subscriber disregards the statute's choice and directive that such information be provided to consumers through the annual reports themselves and the web portal.

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[1] AHIP Comments on MLR Final Rule CMS 9998-FC 1-6-2012

Moreover, imposing an additional, unnecessary administrative cost is flatly inconsistent with the purpose of the MLR provision. The Notice of Information to non-recipients of rebates contemplated here contravenes the public notice route chosen by Congress and imposes the very administrative costs that Congress sought to eliminate. The whole point of the rebate mechanism is to limit the proportion of premium revenue that is spent on administrative costs. In adopting it, Congress made careful choices to accomplish transparency goals in the most cost-effective and efficient manner by requiring the health plans to make reports to the Secretary regarding how premium dollars are used, and requiring the Secretary to make these reports and associated information available through the web portal. Adding the requirement to duplicate this disclosure through personalized notices would upset that careful balance and confound Congress's central goal of reducing non-claims costs.

Finally, there is no requirement in the Act that health plans that meet the MLR threshold provide a notice. Although the final rule imposes the requirement that health plans send notices of rebate to ensure that consumers understand why they are receiving rebates, that requirement is related to the statute's requirement that health plans pay rebates. The notices of no rebate, by definition, do not help implement the rebate program. To the contrary, the requirement applies only when the rebate provision is *not* triggered. Accordingly, any statutory authority for the notices of no rebate must be drawn from PHSA § 2718(a), and this section expressly provides a different method for the dissemination of this same information to consumers.

2. **The additional paperwork is a significant cost that should not be placed on health plans that are operating at or above the relevant MLR threshold for the applicable market segment.**

In our comment letter on the MLR Final Rule, we estimated costs of a Notice of Information for non-recipients of rebates at between $2 and $3 per notice, for a total of $200-300 million. The agency has estimated less than $1 per notice for a total of $71 million. Based on our estimates, we believe the agency has underestimated the costs. Requiring health plans to incur significant additional and unnecessary costs to prepare and issue mailings that note that they meet or exceed the MLR threshold is unnecessary and illogical when the intent of the MLR requirement is on the control of administrative costs.

3. **CMS has not yet considered and responded to the comments to the proposal on the Notice of MLR Information for non-recipients of rebates as requested in the MLR Final Rule.**

From a procedural standpoint, we believe it is premature to collect information about the MLR Information Notices to non-recipients of rebates, since CMS is still considering comments on the proposal and has not yet published a final rule requiring a notice be sent to subscribers and

policyholders not receiving rebates. Issuing an ICR asking for comments on the specifics of the notice is premature until the agency determines that a rule requiring the notices is cost-effective and necessary.

Under Executive Order 13563, CMS must propose or adopt a rule "only upon a reasoned determination that its benefits justify its costs." CMS must also "tailor its regulations to impose the least burden on society, consistent with obtaining regulatory objectives, taking into account, among other things, and to the extent practicable, the costs of cumulative regulations." The preamble to the final rule engages in none of this analysis. It did not estimate the burden of the regulation, its benefits, or engage in the required balancing. The estimation of the burden for Paperwork Reduction Act purposes at $71 million cannot substitute for the full analysis required.

MLR Rebate Notices

The sample forms for MLR Rebate Notices contain the information specified in the Final Rule, *§158.250 Notice of rebate*s, in an overly prescriptive format. There is no compelling reason for taking an inflexible and highly prescriptive approach. Other federal notice requirements provide health plans with flexibility in content of notices – such as in the annual notice for the Women's Health and Cancer Rights Act of 1998, and the HIPAA Notices of Privacy Practices. We strongly recommend the same flexible approach be adopted for MLR rebate notices, allowing the information to be issued by health plans in their own form, format and method of distribution.

We also note that prescriptive language is particularly inappropriate as Section 2718 does not require an MLR Rebate Notice at all. We recommend, instead, that the Notices should be refashioned as sample Notices. The President's Executive Order 13563 – Improving Regulation and Regulatory Review - provides helpful guidance in this regard. Section 1 (b) (4) of that Executive Order, specifies the agency must – *"to the extent feasible, specify performance objectives, rather than specifying the behavior or manner of compliance that regulated entities must adopt".*

In addition, the notices fail to meet readability standards. When tested with key readability indices the rebate notices did not achieve the readability level set by regulators for similar notifications or materials – such as using a Flesch index of no higher than 8th grade reading levels. The notices do not meet the Federal Plain Language Guidelines used by federal agencies, and as written will lead to consumer confusion and increased calls. Providing a flexible approach will allow health plans to meet readability standards.

Recommendation: We strongly recommend that health plans be given the flexibility to produce notices that include the information required in §158.250 in more consumer friendly terms.

Below are additional recommendations that can be resolved if health plans are provided the flexibility recommended above:

1. **The forms should refer to "Notice of Health Insurance Rebate", not "Refund"**

The language of Public Health Service Act *§2718* (b) *Ensuring That Consumers Receive Value for Their Premium Payments* 1.(B) *Rebates*, and the language of the Final Rule in 158.250 *Notice of rebate*s both refer to "rebates", not "refunds". This is appropriate because the Final Rule permits the form of the MLR rebate to vary based on the specific situation of the policyholder or consumer. If a policyholder paid by credit card, the rebate could be issued in the form of a credit to that card, or if an electronic funds transfer, through a refund – or credit- to that account. Importantly, rebates may be applied to future premium payments which makes calling these amounts "refunds" particularly inappropriate.

2. **The Sample Forms should give health plans flexibility to describe administrative costs in a way that is accurate and meaningful to consumers. The current prescriptive language is limited and misleading.**

As drafted, the current Sample Forms use prescriptive and limited language to describe administrative costs: "No more than [20/15] percent of premiums may be spent on administrative costs such as salaries and advertising." Requiring health plans to use this language would be misleading and legally improper. A flexible approach allows health plans to describe administrative costs in a way that is accurate, consistent with the regulation, and recognizes that there are many meaningful activities included in administrative costs that are important to consumers such as credentialing of providers, fraud detection activities, and small business access to and compensation of agents and brokers.

3. **In our comment letter on the Final Rule, we urged against the two-step process of requiring health plans to issue rebates to the group policyholder, and then notices to subscribers of the group (the scenario in Sample Form #2). We strongly recommended that the group policyholder be permitted to issue the notice of rebate to employees. We continue to urge your reconsideration of this approach for these reasons:**

Requiring health plans to issue MLR notices separately increases administrative costs to health plans and their customers. It would require the group policyholder to provide reports to the health plan so that the health plan could subsequently issue notices. For example, it would be difficult to administer when the health plan owing the rebate (health plan of reporting year 2011) is not the current (year 2012) group health plan, such as when a carrier exits a market in a state. The 2011 health plan would not have information related to all current (2012) enrollees.

Thus, reliance on the group health plan policyholder would be necessary for that information, further illustrating the rationale for the policyholder to provide notice of rebate to employees or group health plan enrollees.

4. **Sample Form # 2 requires other revisions, if it is not eliminated from use. The opening paragraph would have to be revised to reflect that the *employer* would receive the rebate – otherwise subscribers receiving the notice would be looking for a rebate from health plans. The revision should state "This letter is to inform you that [Health Insurer] will be ~~refunding~~ rebating a portion of ~~your~~ health insurance premiums to your employer."**

The language under that header "Ways in Which an Employer Can Distribute the Rebate" will be difficult for subscribers to follow, causing significant consumer confusion and unnecessary calls to their employers, health plans, or state insurance departments. The health plan must know that information, and act on it, but not the consumer.

This information should be eliminated as unnecessary. Removal of that provision makes the letter much more readable.

5. **The Sample Forms #2 and #3 should allow for a distinction to be made for whether the MLR rebate notice is for a small group or a large group, since there is a material difference in the MLR threshold of 80% for small group and 85% for large group.**

Health plans should be given the flexibility to designate when the notice is being sent to small group or large group customers.

6. **Requiring President/CEO signatures only, with no exceptions, on the notices is not warranted. Officers of the corporations typically sign informational notices to subscribers and group policyholders. Having the officer in charge of the business unit that is sending the rebates will facilitate appropriate handling of calls and information requests.**

We recommend elimination of the "no exceptions" requirement that a President/CEO sign the letters, and allow for signature by an officer of the corporation most directly responsible for responding to information requests.

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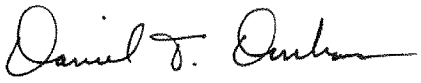
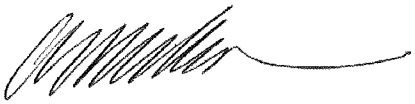
Throughout this letter we have recommended approaches to minimize the administrative burdens, and thus costs to consumers, while meeting the requirements of the ACA and

regulations. This has become an urgent need for an industry that continues to comply with high cost regulatory requirements imposed on it, without appropriate recognition of, or concern for, the impact on operations and administrative costs. We seek your serious consideration of the recommendations we have identified in these comments and welcome the opportunity to discuss them with you.

Sincerely,



Daniel T. Durham
Executive Vice President
Policy and Regulatory Affairs



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January 6, 2012

Attention: CMS-9998-FC
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Final Rule – Medical Loss Ratio Requirements (CMS-9998-FC)
Submitted via www.regulations.gov

Dear Sir or Madam:

We appreciate the opportunity to provide comments on the Final Rule entitled "Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act" ("the Rule") published on December 7, 2011 in the *Federal Register*, especially regarding the treatment of ICD-10 conversion implementation costs, and the process for providing rebates to group enrollees. Our specific comments follow.

ICD-10 Conversion Implementation Costs as Quality Improving Activities

In *§158.150(b)(2)(i)(A)(6) and (c)(5)* of the Rule, the Centers for Medicare and Medicaid Services (CMS) added a recognition of ICD-10 conversion implementation costs as quality improvement activities. This is a positive change that we strongly support. We agree with recognizing the importance of these codes in allowing practitioners to identify and report conditions and condition management in more specific ways that lead to more effective measurements of quality and outcomes.

However, the rule proposes to limit the amount of ICD-10 conversion costs to only those incurred in 2012 and 2013, without recognizing the significant costs health plans have incurred and tracked in 2011, and which they will be required to report on the NAIC Supplemental Health Care Exhibit (the same form on which the proposed federal MLR Reporting form is based). This significant oversight should be corrected by recognition of the conversion costs incurred in reporting year 2011.

Recommendation: We recommend expenses for ICD-10 conversion implementation costs incurred in 2011 also be included in the MLR calculations for 2011.

We also recommend that if CMS delays implementation of the ICD-10 code sets, as some health care providers are recommending, there should be recognition of implementation costs incurred after 2013, consistent with any extension of the implementation timeframe. This is a reasonable consideration, since health insurers would incur additional implementation costs to bridge and maintain dual processing modes and reporting in such a scenario. To be penalized for timely implementation by being prohibited from reporting additional costs (incurred from delays due to other health care systems) would be both unreasonable and unfair.

> **Recommendation: We recommend the timeframe for permitted reporting of ICD-10 conversion implementation costs be consistent with the timeframe CMS sets if there are extensions to the implementation timeframe.**

The Rule also limits – or caps – the amount of ICD-10 conversion implementation costs to 0.3 percent of earned premium in the relevant state market but does not provide a compelling rationale for such a cap. This artificial cap could disadvantage smaller insurers that have significant implementation costs to spread across smaller blocks of business or in fewer states. The cap appears arbitrary and counterproductive at a time when CMS is requiring insurers to lead the implementation process. We thus recommend that the cap be removed.

> **Recommendation: We recommend removal of the 0.3 percent of earned premium cap. In its place we recommend allowing the actual ICD-10 conversion costs to be allocated across the coverage issued in the relevant state markets for years 2011 through 2013 – with extensions past 2013 if CMS's implementation timeframe is extended.**

Distribution of Rebates in Group Markets and Reporting of those Rebates

In *§158.242(b)* "Recipients of Rebates", and *§158.260(c)* "Reporting of Rebates", the Rule permits distribution of rebates owed to those covered under a group health plan through issuing the rebate to the group policyholder. This distribution is subject to certain stipulations as outlined in the rule in *§158.242(b) 1-4*, and through other related guidance such as the Technical Release 2011-04 from the Department of Labor (DOL) and the CMS Interim Final Rule on nonfederal governmental health plans. Allowing for the group policyholder to distribute the rebate to persons covered under the group health plan is a very positive change, for the reasons outlined in the preamble, and as employers have indicated. We support that change. We also recommend that this reliance on the group policyholder – where permitted to distribute rebates to persons covered under the group health plan – should be carried through consistently in *§158.250* "Notice of Rebates".

CMS also provides guidance in *§158.243 (a) (1)* on the determination for *de minimis* rebates when the rebate is provided to the policyholder, which we support.

Recommendation: We recommend that the reliance on the group policyholder to distribute rebates also be reflected in *§158.250* "Notice of Rebates". In addition, we support the provisions for the determination of *de minimis* rebates.

Notice Requirements to Recipients of Rebates

In *§158.250* "Notice of Rebates", the Rule provides guidance on the notice requirements when the rebate is provided to the group policyholder. We note that terminology used in this section at the bottom of page FR76593 could be read in a way that conflicts with the intent stated in the preamble and in the opening paragraph of *§158.250 (a)* "Notice of Rebates".

The terminology that we recommend be modified is the language that states "an issuer must provide to each policyholder who receives a rebate and subscribers whose policyholder receives a rebate….the following information in a form prescribed by the Secretary:" We recommend this notice requirement be met by the issuer providing that information to the policyholder, and the policyholder including it with the rebate issued – or description of how the rebate is used - to the group's covered enrollees.

We thus recommend the phrase read "an issuer must provide each policyholder who receives a rebate ~~and subscribers whose policyholder receives a rebate~~, or each subscriber who receives a rebate directly from an issuer, the following information in a form prescribed by the Secretary:" This would be consistent with the requirements outlined in *§158.242(b),* with the latter reference to each subscriber only in the cases of the exceptions in *§158.242(b) (3) and (4)* – where the notice and rebate would go to the subscriber.

Requiring health plans to issue those notices separately would require the group policyholder to provide reports to the insurer so that the insurer could subsequently issue notices, increasing the administrative costs on both groups and insurers. This requirement would also be very difficult to administer in those cases where the insurer owing the rebate (insurer of reporting year 2011) is not the current (year 2012) group health plan insurer. The 2011 insurer would not have information related to all current (2012) enrollees. Thus, reliance on the group health plan policyholder would be necessary for that information, further illustrating the rationale for the policyholder to provide notice of rebate to employees or group health plan enrollees.

Recommendation: We recommend the Final Rule language in *§158.250(a)* remove the conflicting phrase "*and subscribers whose policyholder receives a rebate*" from the section, as found on the bottom of FR 76593 and top of page FR 76594.

The preamble to the Rule [FR76580] also notes that the Secretary of Health and Human Services (HHS), in consultation with the Secretary of Labor will prescribe the notice of rebates to policyholders and subscribers of group health plans. We respectfully request that HHS and DOL release the proposed language of such notices at the earliest opportunity, to allow public review

and input in January. We also recommend that HHS and DOL provide for flexibility in the method in which the notice of rebate language is delivered to rebate recipients. Health insurers have many channels of communication with enrollees, and will provide the notice via the communication channel most appropriate for the enrollee.

> **Recommendation: We recommend the proposed language for notice of rebate to group policyholders or rebate recipients be released for comment as soon as possible. We further recommend that insurers be permitted flexibility regarding the means by which they issue the notice of rebates.**

Other Comments

Notice of MLRs to Non-Recipients of Rebates

In the preamble to the Rule [FR 76580-76581], CMS considers proposing a Notice of MLR be sent to policyholders *not* receiving rebates, suggesting that showing MLRs for the current reporting year and *the prior year* could be useful to subscribers in predicting what might be expected to happen the next year, and in making plan choices.

There are several significant reasons why the newly proposed reporting requirement would not be helpful to subscribers as suggested in the preamble, but would instead lead to confusion, and have unintended consequences that would add administrative costs and complexity to a process for MLR calculations and reporting that is already onerous. And, this additional red-tape would be imposed on insurers who are already in compliance with the MLR standards. For example, if required to mail out a notice of MLR, insurers would see increased calls in their customer service departments, since sending information that requires no action often results in subscriber confusion. Insurers would also have to incur additional costs to identify the relevant MLR from prior years for coverage for individuals, which is not an element of the MLR calculation on which the current reporting year is based.

The main reason suggested in the preamble for such notice of MLRs is for a predictor of year-to-year premiums or MLRs. Insurers are concerned with this proposal because the MLR for each year is based on the claims in that year and would not necessarily be relevant to another year nor be helpful for consumers for a number of possible reasons:

- MLR values can vary significantly from year to year based on claims and adjustments.
- MLRs are not a predictor of claims experience or premiums.
- Rebates are based on an average MLR adjusted for cumulative credibility. The MLR itself could be below the MLR required value without requiring any rebate. If this is the case for the prior year, showing the prior year MLR will create questions about why no rebate was paid in that year.

- Premium rates may be based on expected results from the experience in a group of states, not just a single state (especially if the business is not credible), so prior MLRs are not an indicator of expected MLRs in that case, either.
- Premium rates for the next year are unlikely to be based on MLRs from two years prior.
- For reporting year 2011, the prior MLR would not have been calculated using the new federal MLR methodology, thus there is no accurate comparison MLR number to provide.
- In reporting year 2013, the three year averaging would affect the prior year comparison number.

Requiring such a notice would add to the administrative burden on insurers and policyholders, creating an unnecessary and overly burdensome regulation. To provide an estimate of the cost and complexity, we reached out to a number of large and small insurers for examples of the impact. The graphic provided in the attached exhibit demonstrates the depth and scope of activities required for this proposed additional requirement. Depending on insurer size, the net cost per notice was between $2.00 and $3.00, which arrived at an estimated impact of $200 - $300 million dollars[1] for this activity.

There is no requirement in the Affordable Care Act that such a notice be provided, and requiring one would create a significant new administrative burden on insurers with no related benefit to consumers. For these reasons, we oppose a new mandate that would require insurers issue to non-recipients of rebates a new Notice of MLR.

> **Recommendation: We strongly recommend that the proposed requirement in the preamble that a Notice of MLR be sent to policyholders *not* receiving rebates should not be adopted.**

Fraud Prevention Expenses as Quality Improvement Activities

We view the non-inclusion of costs related to fraud prevention and detection as a missed opportunity in the MLR Final Rule that should be revisited, and subject to a new notice and comment period in a revision to the rule. We remain concerned that the Rule only allows recoveries from fraud programs to be counted toward the MLR, while capping expenses to prevent or detect fraud – in other words, rewarding and encouraging only the "pay and chase" system that Congress has moved public programs away from. Health insurance plans devote significant resources to fraud prevention and detection programs as part of a broad-based strategy for improving health outcomes and achieving the optimal use of health care dollars. Recognizing that fraud has far-reaching implications both for health care costs and quality,

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[1] *Assuming that the U.S. population is about 300 million individuals – excluding individuals with Medicare and Medicaid (about 95 million individuals), individuals receiving rebates, and dependents – we conservatively estimate that there could be upward of 100 million MLR notices sent.*

health plans have developed cutting-edge techniques to identify fraud and halt practices that lead to substandard care – including the delivery of inappropriate or unnecessary services that may harm patients.

These health plan anti-fraud initiatives are strongly focused on preventing fraud before it takes place, rather than "paying and chasing" after the fact. This approach serves as a powerful deterrent in preventing not only inappropriate billings, but more importantly, preventing inappropriate delivery of unnecessary or inappropriate services from occurring in the first place. The success of health plans' fraud prevention initiatives is evidenced by the fact that government programs now are incorporating these innovative private sector practices.

By taking this approach, the MLR Rule's treatment of fraud prevention expenses works at cross purposes with CMS's efforts to emulate successful private sector programs, and it is at odds with the broad recognition by leaders in the private and public sectors that there is a direct link between fraud prevention activities and improved health care quality and outcomes.

> **Recommendation: We recommend fraud prevention and detection expenses be included as quality improving activities in the MLR methodology of the rule.**

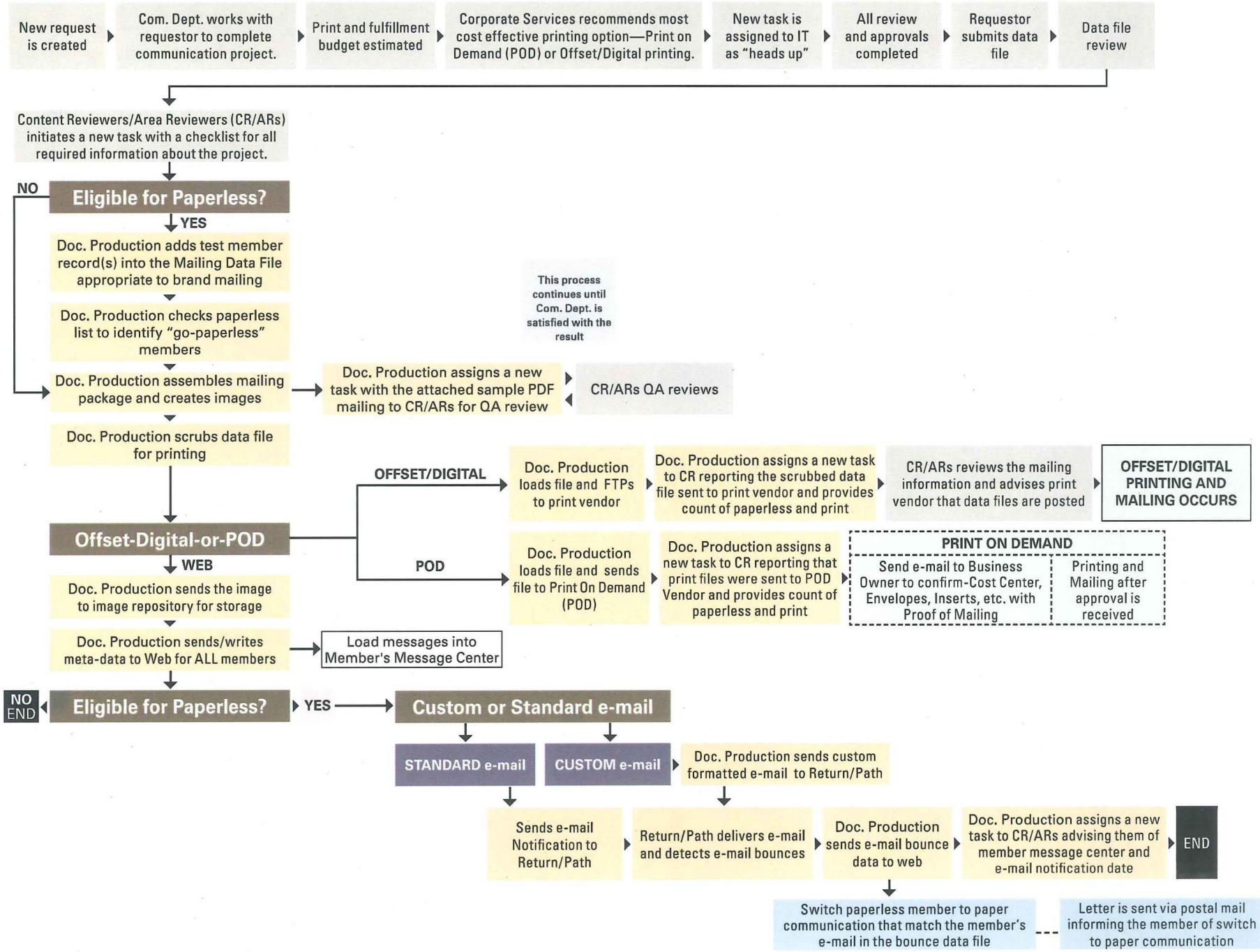
We appreciate the opportunity to provide these comments on the Final Rule, and look forward to working with you in constructive approaches to implementation of the requirements of the ACA.

Sincerely,

Daniel T. Durham
Executive Vice President
Policy and Regulatory Affairs

Colleen M. (Candy) Gallaher
Senior Vice President
State Policy

Mass Mailing Process



Notice of Health Insurance Premium Refund

[August 1, 20XX **1**]

[Subscriber Name **2a**
123 Main Street **2b**
Anytown, USA **2c**]

Re: Health Insurance Premium Refund for Year [20XX **3**]; [Policy #XXXXX **4**]

Dear [Subscriber Name **5**]:

This letter is to inform you that you will receive a refund of a portion of your health insurance premiums. This refund is required by the Affordable Care Act – the health reform law.

The Affordable Care Act requires [Health Insurer **6**] to issue a refund to you if [Health Insurer **7**] does not spend at least 80 percent of the premiums it receives on health care services, such as doctors and hospital bills, and activities to improve health care quality, such as wellness programs. No more than 20 percent of premiums may be spent on administrative costs such as salaries and advertising. This requirement is referred to as the "Medical Loss Ratio" standard or the "80 / 20 rule". The 80 / 20 rule in the Affordable Care Act is intended to ensure that consumers get value for their health care dollars. You can learn more about the 80/20 rule and other provisions of the health reform law at: http://www.healthcare.gov/law/features/costs/value-for-premium/index.html.

[The Affordable Care Act allows States to apply for a lower ratio. In [20XX **8**], your State applied for and received a temporary adjustment to the 80/20 rule. For [20XX **9**], [Health Insurer **10**] must meet a [XX% **11**] Medical Loss Ratio, meaning that [XX% **12**] of premiums must be spent on medical services and activities to improve health care quality, and no more than [XX% **13**] of premiums can be spent on administrative costs. Additional information on State requests for an adjustment to the 80 /20 rule can be found at: http://cciio.cms.gov/programs/marketreforms/mlr/index.html].

[The Affordable Care Act allows States to require health insurers to meet a higher ratio. [Your State sets a higher Medical Loss Ratio standard, so [Health Insurer **14**] must meet a [XX% **15**] Medical Loss Ratio, meaning that [XX% **16**] of premiums must be spent on medical services and activities to improve health care quality, and no more than [XX% **17**] of premiums may be spent on administrative costs].

What the Medical Loss Ratio Rule Means to You

The Medical Loss Ratio rule is calculated on a State by State basis. In your State, [Health Insurer **18**] did not meet the Medical Loss Ratio standard. In [20XX **19**], [Health Insurer **20**] spent only [XX% **21**] of a total of [$YYY **22**] in premium dollars on health care and activities to improve health care quality. Since it missed the [80 percent target / target in your State **23**] by [X% **24**] of premiums it received, [Health Insurer **25**] must refund [X% **26**] of your health insurance premiums. We are required to provide this refund to you by August 1, [20XX **27**].

[We are enclosing a check/We are sending you a check separately from this letter/We are giving you this refund by reducing your next premium payment/We are issuing a credit to the credit or debit card you used to pay your premium **28**]. [OPTIONAL FOR ISSUERS: Your refund/credit is $XX **29**].

Need more information?

If you have any questions about the Medical Loss Ratio and your health insurance coverage, please contact [Health Insurer **30**] toll-free at [1-XXX-XXX-XXX **31**].

Sincerely,

[John Doe, President and CEO **32**]
[Health Insurer **33**]

Notice of Health Insurance Premium Refund

[August 1, 20XX **1**]

[Subscriber or Policyholder Name **2a**
123 Main Street **2b**
Anytown, USA **2c**]

Re: Health Insurance Premium Refund for Year [20XX **3**]; [Policy #XXXXX **4**]

Dear [Subscriber or Policyholder Name **5**]:

This letter is to inform you that [Health Insurer **6**] will be refunding a portion of your health insurance premiums. This refund is required by the Affordable Care Act – the health reform law.

The Affordable Care Act requires [Health Insurer **7**] to refund part of the premiums it received if it does not spend at least [80/85 **8**] percent of the premiums [Health Insurer **9**] receives on health care services, such as doctors and hospital bills, and activities to improve health care quality, such as wellness programs. No more than [20/15 **10**] percent of premiums may be spent on administrative costs such as salaries and advertising. This is referred to as the "Medical Loss Ratio" standard or the [80/20 85/15 **11**] rule. The [80/20 85/15 **12**] rule in the Affordable Care Act is intended to ensure that consumers get value for their health care dollars. You can learn more about the [80 /20 85/15 **13**] rule and other provisions of the health reform law at: http://www.healthcare.gov/law/features/costs/value-for-premium/index.html.

[The Affordable Care Act allows States to require health insurers to meet a higher ratio. Your State sets a higher Medical Loss Ratio standard, so [Health Insurer **14**] must meet a [XX% **15**] Medical Loss Ratio, meaning that [XX% **16**] of premiums must be spent on medical services and activities to improve health care quality, and no more than [XX% **17**] of premiums can be spent on administrative costs.]

What the Medical Loss Ratio Rule Means to You

The Medical Loss Ratio rule is calculated on a State by State basis. In your State, [Health Insurer **18**] did not meet the [80/20 85/15 /target in your state **19**] standard. In [20XX **20**], [Health Insurer **21**] spent only [XX% **22**] of a total of [$YYY **23**] in premium dollars on health care and activities to improve health care quality. Since it missed the [80 85 percent target / target in your State **24**] by [X% **25**] of premium it receives, [Health Insurer **26**] must refund [X% **27**] of the total health insurance premiums paid by the employer and employees in your group health plan. We must send this refund to your employer by August 1, [20XX **28**]. Employers or group policyholders must follow certain rules for distributing the refund to you.

Ways in Which an Employer Can Distribute the Refund

If your group health plan is a non-Federal governmental plan, the employer or group policyholder must distribute part of all of the refund in one of two ways:

- Reducing premium for the upcoming year; or
- Providing a cash refund to employees or subscribers that were covered by the health insurance on which the refund is based.

If your group health plan is a church plan, the employer or group policyholder has agreed to distribute the portion of the refund that is based on the total amount all of the employees contributed to the health insurance premium in one of the ways discussed in the preceding paragraph.

If your group health plan is not a governmental plan or a church plan, it likely is subject to the federal Employee Retirement Income Security Income Act of 1974 (ERISA). Under ERISA, the employer or the administrator of the group health plan may have fiduciary responsibilities regarding use of the Medical Loss Ratio refunds. Some or all of the refund may be an asset of the plan, which must be used for the benefit of the employees covered by the policy. Employees or subscribers should contact the employer or group policyholder directly for information on how the refund will be used. For general information about your rights regarding the refund, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or review the Department's technical guidance on this issue on its web site at http://www.dol.gov/ ebsa/newsroom /tr11-04.html.

Need more information?

If you have any questions about the Medical Loss Ratio and your health insurance coverage, please contact [Health Insurer **29**] toll-free at [1-XXX-XXX-XXX **30**].

Contact your employer or Administrator directly for information on how the refund will be distributed. For general information about your rights regarding the refund if your group health plan is subject to ERISA, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or review the Department's technical guidance on this issue on its web site at http://www.dol.gov/ ebsa/newsroom /tr11-04.html.

Sincerely,

[John Doe, President and CEO **31**]
[Health Insurer **32**]

Notice of Health Insurance Premium Refund

[August 1, 20XX **1**]

[Subscriber Name **2a**
123 Main Street **2b**
Anytown, USA **2c**]

Re: Health Insurance Premium Refund for Year [20XX **3**]; [Policy #XXXXX **4**]

Dear [Subscriber Name **5**]:

This letter is to inform you that you will receive a refund of a portion of your health insurance premiums. This refund is required by the Affordable Care Act – the health reform law.

The Affordable Care Act requires [Health Insurer **6**] to refund part of the premiums it received if it does not spend at least [80/85 **7**] percent of the premiums [Health Insurer **8**] receives on health care services, such as doctors and hospital bills, and activities to improve health care quality, such as wellness programs. No more than [20/15 **9**] percent of premiums may be spent on administrative costs such as salaries and advertising. This is referred to as the "Medical Loss Ratio" standard or the [80/20 85/15 **10**] rule. The [80/20 85/15 **11**] rule in the Affordable Care Act is intended to ensure that consumers get value for their health care dollars. You can learn more about the [80/20 85/15 **12**] rule and other provisions of the health reform law at: http://www.healthcare.gov/law/features/costs/value-for-premium/index.html.

[The Affordable Care Act allows States to require health insurers to meet a higher ratio. Your State sets a higher Medical Loss Ratio standard, so [Health Insurer **13**] must meet a [XX% **14**] Medical Loss Ratio, meaning that [XX% **15**] of premiums must be spent on medical services and activities to improve health care quality, and no more than [XX% **16**] of premiums can be spent on administrative costs].

What the Medical Loss Ratio Rule Means to You

The Medical Loss Ratio rule is calculated on a State by State basis. In your State, [Health Insurer **17**] did not meet the [80/20 85/15 /target in the state **18**] standard. In [20XX **19**], [Health Insurer **20**] spent only [XX% **21**] of a total of [$YYY **22**] in premium dollars on health care and activities to improve health care quality. Since it missed the [80 85 percent target / target in your State **23**] by [X% **24**], [Health Insurer **25**] must refund [X% **26**] of the total health insurance premiums paid by the employer and employees in your group health plan. We must send this refund by August 1, [20XX **27**].

Rebate Distribution Method

[Health Insurer **28**] is distributing the refund based on the total premium paid your group health plan directly to the employees or subscribers in the group health plan. The refund is being distributed evenly among these subscribers. [We are enclosing a check/We are sending you a check separately from this letter **29**].

Need more information?

If you have any questions about the Medical Loss Ratio and your health insurance coverage, please contact [Health Insurer **30**] toll-free at [1-XXX-XXX-XXX **31**].

Sincerely,

[John Doe, President and CEO **32**]
[Health Insurer **33**]

SAMPLE
Notice of Issuer's Medical Loss Ratio

[August 1, 20XX **1**]

[Subscriber or Policyholder Name **2a**
123 Main Street **2b**
Anytown, USA **2c**]

Re: [Health Insurer **3**] Medical Loss Ratio for [20XX **4**]

Dear [Subscriber or Policyholder Name **5**]:

This letter is to inform you that in [20XX **6**] [Health Insurer **7**] has met or had a higher Medical Loss Ratio than the [80/20 85/15 **8**] standard required by the Affordable Care Act – the health reform law. This letter explains what this means.

The Affordable Care Act requires [Health Insurer **9**] to spend at least [80/85 **10**] percent of the premiums it receives on health care services, such as doctors and hospital bills, and activities to improve health care quality, such as wellness programs. No more than [20/15 **11**] percent of premiums may be spent on administrative costs such as salaries and advertising. If [Health Insurer **12**] does not do so, it must refund part of your premium. This requirement is referred to as the "Medical Loss Ratio" standard or the "[80/20 85/15 **13**] rule". The [80/20 85/15 **14**] rule in the Affordable Care Act is intended to ensure that you get value for your health care dollars. You can learn more about the [80/20 85/15 **15**] rule and other provisions of the health reform law at: http://www.healthcare.gov/law/features/costs/value-for-premium/index.html.

[The Affordable Care Act allows States to apply for a lower ratio. In [20XX **16**], your State applied for and received a temporary adjustment to the 80/20 rule. For [20XX **17**], [Health Insurer **18**] must meet a [XX% **19**] Medical Loss Ratio, meaning that [XX% **20**] of premiums must be spent on medical services and activities to improve health care quality, and no more than [XX% **21**] of premiums may be spent on administrative costs.]

[The Affordable Care Act allows States to require health insurers to meet a higher ratio. Your State sets a higher Medical Loss Ratio standard, so [Health Insurer **22**] must meet a [XX% **23**] Medical Loss Ratio, meaning that [XX% **24**] of premiums must be spent on medical services and activities to improve health care quality, and no more than [XX% **25**] of premiums can be spent on administrative costs.]

What the Medical Loss Ratio Rule Means to You

The Medical Loss Ratio rule is calculated each year on a State by State basis. In [20XX **26**], [Health Insurer **27**] met the Medical Loss Ratio standard. In [20XX **28**], [Health Insurer **29**] spent [XX% **30**] of a total of [$XXX **31**] in premium dollars on health care and activities to improve health care quality – [$XXX **32**] above the minimum standard.

[Health Insurer **33**] has met the Affordable Care Act's Medical Loss Ratio minimum, indicating that you are receiving the required value for your health care dollars.

Sincerely,

[John Doe, President and CEO **34**]
[Health Insurer **35**]