VIVA HEALTH®

Oct. 21, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9982-NC
P.O. Box 8016
Baltimore, Maryland 21244-1850
Submitted via upload at www.regulations.gov

Re: Summary of Benefits and Coverage and Uniform Glossary

Dear Sir or Madam:

Thank you for the opportunity to offer comments on the proposed regulations governing the summary of benefits and coverage (SBC) provisions of the Affordable Care Act. VIVA Health is licensed as an HMO in Alabama and is headquartered in Birmingham. We serve more than 80,000 members through fully insured commercial plans, administrative services for self-funded plans and Medicare Advantage plans.

March 2012 is too soon for implementation.
Our first comment is a general one about the timetable. Implementation of the new requirements cannot possibly be achieved by March 2012. Health plans and employers need at least 12 months to ramp up before an effective date. The current scenario anticipates compliance with only a few months notice after issuance of proposed regulations and virtually no notice after final regulations are issued.

Premium costs should not be included on the SBC.
Another major concern is the requirement to list premium cost for group health plans. Such a premium is not instructive to an employer prospectively before medical underwriting. The challenge of providing a premium before medical underwriting is compounded on the large group side, where employers have a large variety of plan design choices to make before a premium can be established. Even retrospectively, providing a premium figure would be tricky for group coverage because insurers do not know the cost per employee net of employer contribution. Therefore, even the correct figure would be meaningless to the average employee. Please consider eliminating this overly burdensome and unhelpful addition to the SBC. We believe lawmakers did not include premium in the statute's description of the SBC for good reason.

SBCs are not feasible and are unnecessary for large groups until open enrollment time.
Absent the premium, insurers could more easily provide small groups the SBC prospectively. However, the issue raised about large groups above also affects an insurer's ability to provide an SBC to a group that is merely shopping. Until a large group settles on a plan design, provision of an SBC would amount to nothing more than a list of bracketed numbers in a large range for most of the document. Large employers are savvy insurance consumers and do not need the help

an SBC provides. The earliest an insurer should be required to provide an SBC to large groups is at open enrollment when employees are making their coverage selections.

Expand the provider columns on page 2 of the SBC.
The two columns of "Participating Provider" and "Non-Participating Provider" do not allow insurers the option of having preferred providers, non-preferred but participating providers and non-participating providers. More and more, groups are looking to restrict their networks to lower premium costs. The SBC should allow for such a strategy. We believe the columns would be better if they were split into three choices: Preferred Provider, Non-Preferred Provider and Out-of-Network Provider.

Simplify requirement however possible.
We believe the regulations far underestimate the cost and burden of the SBC requirement. One way to lessen the burden is to reduce customization requirements, such as issuing a different SBC to someone with family coverage versus single coverage. One document can simply describe both scenarios. Also, we would have to reconfigure our I.T. system to allow us to automatically mail dependents an SBC if they have an address other than the subscriber's address. We believe dependents should go on the website or call customer service if they want their own SBC. Expanding or changing coverage examples as much as annually and potentially giving plans as little as 90 days' notice to do so is not in the best interest of anyone.

Benefit enhancements should not require 60 days' notice.
We understand the need for advance notice of adverse material modification. But to what end should an insurer delay a mid-year benefit enhancement? We believe those should be immediately effective to benefit the members.

Thank you for your attention to our concerns. We would be happy to respond to any questions.

Sincerely,

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