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October 18, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9982-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: **CMS-9982-P**
Proposed Rule Regarding Patient Protection and Affordable Care Act;
Summary of Benefits and Coverage and the Uniform Glossary

Cigna is pleased to respond to the request made by the Departments of Health and Humans Services, Labor and Treasury for comments to assist in the development of final rules for group health plans and health insurance coverage relating to the Summary of Benefits and Coverage (the “**SBC**”) and the Uniform Glossary.

Cigna is a global, health insurance and service organization dedicated to helping people around the world improve their health, well being and sense of security. We provide an integrated suite of insured and self-insured medical, dental, behavioral health, pharmacy and vision care benefits. The rules for implementing the SBC requirements under the Patient protection and Affordable Care Act will have a significant impact upon the Cigna companies and the clients and customers we serve. We, therefore, appreciate the Departments’ willingness to receive comments on this important subject.

At the outset, we would comment generally that we are concerned that the proposed rules reflect an interpretation of Section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act (“**PPACA**”) which fails to properly account for the substantial investment that health insurance issuers and the sponsors of group health plans have already made in attempting to ensure that individuals fully understand the

terms of their coverage and make optimum use of the benefits available to them. We wholeheartedly agree that successful, long term health care reform and the containment of medical costs requires that individuals be empowered through information to become better informed shoppers for health care services. Health insurance issuers and sponsors of group health plans have led the way in providing meaningful transparency tools that provide access to information on the cost and quality of specific health care services and specific health care providers. Health insurance issuers, employers and other groups sponsoring group health plans already provide Summary Plan Descriptions (SPD) as required by ERISA, as well as in benefit summaries that are customized to provide information in the format preferred by their employee population. They also provide highly-customized tools and information to individuals when they enroll during open enrollment periods or otherwise. The final regulations should build on these efforts and leverage them as much as possible. The proposed regulations do not do so. As currently proposed, the rules require the provision of an unrealistically rigid SBC that will too often be no more than redundant if even relevant and will have the unintended consequence of confusing or overwhelming consumers rather than making them better informed. And it will add additional cost to the system.

Comments on specific provisions in the proposed rules are set forth below:

1. Effective Date and Implementation Timing

The statute intended to provide insurers and group health plans a full year from the time of issuance of regulations to implement the SBC and uniform summary. However, since final regulations are not expected until the end of 2011, insurers and plans will have only a few months to implement this complicated and time consuming requirement. Cigna has approximately 70,000 plans with varying benefits and coverage levels. Implementation of this requirement for such a large volume of plans in the time allowed is not feasible without resorting to a prohibitively expensive, short term, manual method to produce the SBCs based on assumptions regarding the regulatory requirements (given the number of outstanding questions), followed by a great deal of expensive re-work to implement a final solution. Sponsors of self-insured group health plans face the same problems and they have even fewer resources to ensure compliance.

Most of the health insurance reform provisions in the PPACA are effective with the first plan year beginning on or after a date which is either 6 months or one year after the effective date of PPACA or after regulations are issued. However, the statute provides that the SBC must be provided "prior to any enrollment restriction" on or after March 23, 2012 without regard to plan year. The proposed rules provide no clarification of the effective date. As a result, insurers and all group health plans must be prepared to provide an SBC on March 23, 2012, without regard to plan year. It would be an enormous and costly task for Cigna to produce the SBC for approximately

70,000 existing plans each with different benefit designs. This will also create an additional burden on employers. Producing the SBC's twice, once for new enrollees and again at renewal during the first year of implementation dramatically increases the work effort and expense required to comply. Therefore, we recommend implementing the documents on renewal based on the plan's first plan year on or after the effective date.

We also recommend that the final regulations provide sufficient time for health insurance issuers and group health plans to implement the new requirements by:

- (i) Providing a safe harbor for large employer group health plans that provide this information through the summary plan description in conformance with ERISA requirements and other summary materials. Alternatively, if a safe harbor is not possible, allow large employer group health plans to provide specified information in their own summary format following a specific order, but not restricted to the SBC format recommended by the NAIC;
- (ii) Delaying implementation or providing a non-enforcement period for at least 18 months following the release of the final regulations, and
- (ii) Clarifying that the requirement to provide the SBC applies based on the plan's first plan year on or after the delayed effective date or non-enforcement period.

2. Application of SBCs for Requests for Information

Requests for information by group health plans typically involve questions regarding an insurer's system capabilities and functionality rather than the benefit available. And for good reason. Unlike the individual insurance segment, in the case of group health plans the health insurance issuer does not determine the benefits, the plan sponsor does. Normally, when shopping for a new health insurance issuer, the plan sponsor requires that the health insurance issuer duplicate its current benefits. Moreover, the sales process typically involves a great deal of interaction and negotiation between the health insurance issuer, the broker/consultant and the employer or other group sponsoring the group health plan. Brokers/consultants and groups sponsoring group health plans are very sophisticated and typically expect much more detailed and different information than would be provided in the SBC. Therefore, providing an SBC to the employer or other group that determines the benefits under the plan it sponsors serves no purpose. Worse, it adds needless cost to the health care system. To avoid the unintended consequence of adding cost to the health care system under circumstances where providing an SBC serves no useful purpose, it is recommended the final regulation exempt requests for information received from sponsors of group health plans from the requirement to provide an SBC.

Alternatively, providing “off the shelf” generic sample SBCs without premium rates to the group health plan sponsor or its representative (broker or consultant) but only upon specific request should be treated as satisfying the requirement for providing an SBC to the group health plan.

3. Separate SBCs Based on Coverage Tiers

The proposed regulation currently requires a separate SBC to be provided by coverage tier. Group health plans often include multiple benefit options, vary the cost-sharing and premium by tier, and often have 4 or more coverage tiers (e.g., employee only coverage, employee + spouse coverage, employee + child coverage, employee + family coverage). Creating separate SBCs by coverage tier for each offered plan at enrollment would generate an overwhelming number of documents for the employees to review, generate unnecessary confusion and added costs for health insurance issuers and sponsors of group health plans. For example:

ABC Company offers 3 plans (Indemnity, PPO and EPO) each with 4 coverage tiers. This would require 12 SBCs to be provided to each employee of ABC Company. If ABC Company also provides 2 pharmacy options (not an uncommon occurrence), ABC Company employees would then potentially receive 24 SBCs!

For automatic enrollments, the proposed regulation requires that employees be provided the SBC specific to the plan and coverage tier in which they are currently enrolled. Since this would not provide employees with a view of all options available, we expect that most employers and employees will request that SBCs for all options be provided at open enrollment.

For both initial enrollments and renewals, we recommend that the final regulations allow health insurance issuers and group health plans the flexibility to consolidate all coverage tiers in one SBC and eliminate the “Coverage For” field. This would provide consumers a view of all tiering options available, simplify the SBC materials, and reduce costs.

4. Premium

The proposed regulations require that the SBC include the premium for the plan, although this is not an element required by the statute. This is a very onerous task and likely to provide misleading information to individuals considering enrollment in a group health plan.

At the point an employer or other entity sponsoring a group health plan initially requests information about new or renewing group health insurance coverage, there is often not enough information concerning the eligible participants or plan design for the issuer to estimate the premium. Rates are not finalized until some time later in the sales/renewal process after benefits are finalized and enrollment predicted. Accordingly, it is recommended that the final regulations not require a health insurance issuer to include premium rates in the SBC that is required to be provided to a group health plan or its sponsor until after final benefits are determined.

In the case of insured group health plans, the employer and employees typically contribute to the cost of coverage. Therefore, displaying the total premium cost would be misleading to the employee who would be interested only in what he/she would actually be required to contribute. The employee contribution amount is information that would be available to the employer or other entity sponsoring the plan, but not to the health insurance issuer. It is recommended, therefore, that the final regulations indicate that if the SBC is provided by the health insurance issuer, that the health insurance issuer not be required to identify the premium and, instead, indicate that the employee's premium contribution amount is available from the group policyholder.

In the case of individual health insurance, the premium is underwritten based upon individual risk characteristics. Requiring the inclusion of the premium in the SBC for individual insurance coverage would require that a separate SBC be created for each individual. This would significantly increase processing time and costs. It is recommended that the final regulations not require that the premium be included in the SBC for individual insurance policies if the premium is provided in a separate document.

5. SBC Content

Further clarification is needed regarding content of the SBC:

- The proposed rules and NAIC instructions do not reference the ability to add or modify the name of the plan sponsor or plan. It is common for spouses to have coverage through a different employer and for both plans to be insured and/or administered by the same insurer or third party administrator. To avoid confusion for enrollees, we recommend that the SBC header include the name of the plan sponsor and/or the group health plan to avoid confusion in these circumstances.
- The section of the SBC beginning with "If you have a recovery or other special health need," lists "Hospital service" as a possible service for which cost sharing should be shown. It is unclear what services are embraced by the term, "hospital

services.” The final regulations should either clarify that this should be “Hospice services,” as indicated in the summary format for individual plans on the portal, or explain what services are embraced by “Hospital services.”

- The sample SBC provided by the NAIC does not follow the associated instruction document in several places. For example,
 - (i) the font in the sample is not the required font, and
 - (ii) the network of providers row on page 1 does not include a statement required by the instructions; where there is no cost-share for the member, the instructions indicate showing “No charge,” but the sample shows “0% co-insurance.”

There are other disconnects as well. These disconnects make it difficult to know if the SBCs are completed properly and will likely result in content variations in SBCs produced by different parties. It is recommended that the examples conform to the instructions to eliminate confusion.

6. Coverage Examples

The Coverage Examples pose several issues for health insurance issuers and group health plans:

- The proposed rules indicate that the allowed amounts will be updated annually and health insurance issuers and group health plans are required to update their Coverage Examples within 90 days of a change. We recommend that:
 - (i) the final regulations require HHS updates to be implemented within 90 days. To ensure consistent application of updates across carriers and to accommodate the timing of the large employer sales cycle which often begin six months or more prior to the coverage effective date we recommend HHS provide updates in the first quarter of each year and be effective based on a coverage renewal beginning with the following January plan year. Note large accounts begin their enrollment process well in advance of the effective date.
 - (ii) issuers and group health plans be allowed to sign up to receive timely HHS website updates notifying them when allowed amounts or medical scenarios have been changed.

- The NAIC instructions only provide a completed template for the Breast Cancer scenario. Additional background information (i.e., codes, treatment dates, etc.) is required to complete the diabetes and maternity scenarios. To allow sufficient time for the Departments, health insurance issuers and group health plans to implement additional coverage examples, we recommend that the final regulations adopt a phased-in approach starting with only the Breast Cancer example and adding other examples as details become available.
- The cost of producing SBCs will continue to increase as each Coverage Example is added. This includes costs associated with IT development and resources to calculate and implement the examples specific to each plan (currently 70,000 in the case of Cigna), increased shipping costs due to additional Coverage Example pages, and increased inquiries from plan participants regarding the new scenarios and calculations. In light of this, we recommend the creation of a universal tool, hosted on healthcare.gov, for consumers to compare benefit plans and costs for the Coverage Examples. This would be an efficient, “green” alternative and ensure consistency across health insurance issuers and plans while providing ease and flexibility for the consumer and management oversight to the federal government. This would enable the development of multiple Coverage Examples meeting the needs of the general population and allow consumers to select only those medical scenarios applicable to their situation. For example, a single male may not be interested in any of the medical scenarios provided in the proposed rules. An online tool would permit the consumer to input information (deductible, co-pays, co-insurance) directly from their SBC into the online tool for only the scenario of concern to him/her and the tool would automatically calculate the estimated cost. Such a single source used by all health insurance issuers and group health plans would ensure consistent application of data and output allowing consumers to compare on an apples to apples basis.

7. Online Policy and Certificate

The requirement to provide the policy/certificate online pre-enrollment means that health insurance issuers and group health plans must produce all policies, certificates and summary plan descriptions prior to the group health plan’s renewal date in order to create the linkage necessary to identify the document to the plan participant. The SBC footer requires inclusion of a web address where individuals can review and obtain a copy of the group insurance certificate online. In the case of insured group health plans, the coverage and applicable premium rates are frequently not finalized until shortly before the effective date of the group insurance coverage. As a result, final group insurance certificates may not be available in time to post them online for pre-enrollment. In recognition of this practical reality, the ERISA rules do not require that the plan summary plan description materials be made available until 90 days after an individual enrolls in the plan. It is recommended that the final regulations modify the

statement on the SBC to reflect online policy/certificate availability consistent with the ERISA requirements of 90 days post enrollment.

8. Providing the SBC Electronically

The Preamble to the proposed regulation indicates that the SBC can be provided electronically if the ERISA safe harbor provisions are followed. This requires that the health insurance issuer request acknowledgment of receipt. We recommend the final regulation clarify that the party providing the SBC electronically is responsible for requesting acknowledgment of receipt.

The Departments invited comments on whether any clarifications are needed with respect to the 'readily accessible' standard for electronic disclosure. We recommend that the final regulations clarify that providing sufficient information to reasonably access to the SBC satisfies the 'readily accessible' standard.

9. Issuance at Enrollment/Eligibility

The requirement to provide the SBC prior to enrollment or within 7 days of a request should be clarified as a group health plan responsibility. Enrollment and eligibility with respect to group health plans is typically administered by the employer or other entity sponsoring the group health plan. In the case of an insured group health plan, the insurer typically would not be apprised of enrollment or eligibility changes with respect to its coverage until well after the enrollment or eligibility change becomes effective. Health insurance issuers with respect to insured group health plans are not, therefore, in a position to provide the SBC prior to enrollment; only the employer or other entity administering enrollment is in a position to do that. In recognition of this fact, it is recommended that the final regulations clarify that the health insurance issuer with respect to an insured group health plan can satisfy its obligation to provide an SBC during the enrollment process by making copies of the SBC available to the plan sponsor for distribution to enrollees.

We question why the requirement to provide an SBC has been extended in the proposed regulation to individuals other than the individual who is eligible to enroll for coverage in a group health plan. The proposed regulation requires the provision of an SBC "to a participant or beneficiary" as each is defined in ERISA. However, the law (section 2715) applies the SBC requirement to "applicants, enrollees, and policyholder or certificate holders." In using these terms, we believe that Congress intended that the SBC be made available to those individuals in a position to enroll for coverage through their employment by or membership with the entity sponsoring the group health plan; not their spouses or dependents who may obtain coverage through them,

but who have no right themselves to enroll for coverage. Logically, the individual who can exercise the option of enrolling in a particular group health plan should receive the SBC to assist him/her in deciding whether to enroll and in which plan to enroll. We further note that group insurance policies and group health plans typically make all benefits payable only to the employee who enrolled for coverage. As a result, his/her covered spouse and dependents may not themselves make a claim for benefits under the plan. This is important in light of the fact that ERISA (section 3(8)) defines a "beneficiary to mean "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit there under." If the benefits of a group insurance policy or group health plan are only payable to the enrolled employee, then neither the spouse nor any dependent is a "beneficiary" as defined in ERISA. It is recommended that the final regulation make clear that if benefits under an insurance policy or group health plan are not payable to an individual, then that individual is not a "beneficiary" as defined in section 3(8) of ERISA and the obligation to provide an SBC does not apply to such individuals.

10. Issuance 30 days Prior to Automatic Enrolment

Occasionally, the employer or other entity sponsoring an insured group health plan does not respond to its current insurer's offer to renew the insurance coverage for the group health plan. The insurer may not learn of the policyholder's decision not to renew until just before the renewal date which may be less than 30 days prior to the automatic renewal effective date. Not knowing whether its policy will be renewed, the insurer has no choice but to provide SBCs to current enrollees. But if the employer elects to change insurers, this will result in both the current insurer and the replacement insurer issuing SBCs to enrollees. This will result in confusion for enrollees as they will have two SBCs, one of which is inapplicable. It is recommended, therefore, that the final regulations clarify that the SBC is not required to be provided by an issuer to participants and beneficiaries until after the group policyholder has confirmed its intent to renew coverage for the following year.

11. 60 Day Notice of Material Modification

We applaud the Departments' direction that the 60 day notice of material modification does not apply to changes made at plan renewal. However, the final regulations should also clarify that inadvertent mistakes, such as typographical errors, do not fall under the material modification requirement. Additionally, the final regulations should clarify that reissuance of the corrected SBC will serve as the notice of material modification thereby eliminating the need for a separate notice explaining the change(s).

12. Benefit “Carve-out”

Insured group health plans often provide pharmacy and/or behavioral care benefits through an insurer that is different than the one covering other medical benefits. This situation is referred to as a benefit “carve-out.”

In a “carve-out” situation, the medical benefits insurer does not have information on the carve-out benefits. Likewise, the carve-out benefits insurer would not have any knowledge of the other medical benefits. It is recommended, therefore, that the final regulations clarify that the SBC provided by the issuer of a group insurance policy is required to describe only the benefits it covers.

13. Applicability to Standalone Health Reimbursement Arrangements

The proposed regulation does not provide an exception for standalone HRAs. However, if an SBC is required for a standalone HRA, all of the fill-ins will reflect “\$0” or “No” or “None.” The result will be the production of an SBC that is unnecessary and not at all useful to employees. It is recommended that the final regulation exempt standalone HRAs.

14. Mandatory Notices

The proposed SBC format does not contain the mandatory notices for Grandfathered plans, direct access to OB/GYNs, PCP choice, and annual limit waivers. The existing regulations relating to these notices require that these notices be included in all materials that explain the benefits. That would seem to include the SBC. We recommend that the final regulations provide direction on whether these required notices are to be included in the SBC and, if so, designate the location.

15. Contact Information for Grievances & Appeals

The NAIC instructions require updating to complete the appropriate phone numbers and web addresses regarding grievances and appeals. The jurisdiction and contact information varies based on the state in which the insurance policy is situated or the individual’s residence state and this contact information can change frequently. Since group health plans can have employees in multiple states, requiring the state specific contact information would increase the number of SBCs astronomically as well as the likelihood that an incorrect version will be provided to an employee. Therefore, we recommend that the SBC instructions and final regulations be revised to require the web address where the Consumer Ombudsman information is posted on

www.healthcare.gov rather than requiring each SBC to provide the information specific to that plan or residence state.

16. Preemption of State Law

The proposed regulation states that the federal requirements do not preempt state laws that require an insurer to provide an SBC that supplies more information than is required by the federal regulations. State regulators have review and approval authority over insurance-related materials and this would extend to SBC and Uniform Glossary documents. Additionally, some state advertising laws would likewise require the SBC and Uniform Glossary to be filed and approved by the state as an advertisement. To ensure that state specific changes are not required by state regulators, it is recommended that the final regulations encourage state regulators to waive any form or advertising filing and approval requirements with respect to the SBC and Uniform Glossary.

17. Uniform Glossary

We recommend that:

- The instructions identify the government website URL where the Glossary will be posted.
- The final regulations eliminate the requirement that the Glossary identify the health insurance issuer or group health plan website and phone number for obtaining a copy of the policy and include a generic statement that the policy can be obtained through the website or phone number listed on the SBC. This will enable a generic version of the Glossary to be made available.

18. Instructions

There are various issues that require clarification or correction with regard to the instructions:

- The instructions do not provide guidance on how to address the situation where the policy period differs from the benefit accumulation period for deductibles and out-of-pocket limits. Group health plans often have an off-calendar year policy period or plan year, but benefits accumulate based on a calendar year. Additionally, individual policies typically renew on a month-by-month basis while benefits accumulate based on a calendar year. The final regulations should explain

how to address the difference between the policy period/plan year and the benefit accumulation period for group health plans and individual insurance policies.

- The NAIC instructions for Group Policies on page 9 indicate that for non-networked plans, the insurer should delete the 4th bullet in the Information Box on page 2 of the SBC and replace it with: “Your costs are the same no matter which provider you see.” The instructions should also indicate that the last bullet on page 6 of the Coverage Examples section (“What are some of the assumptions behind the Coverage Examples?”) should also be removed or modified. This statement currently reads: “The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.”
- In the Common Medical Events section under “If you have a test,” the instructions only indicate potential variances for “provider’s office or clinic.” Diagnostic tests may vary based on place of service. The instructions should allow for identification of cost-sharing based on additional places of service such as urgent care facilities or emergency rooms.
- The SBC includes the terms “habilitation” and “hospital services” under Common Medical Events. However, these terms are not defined. The instructions should clarify the services that are associated with these categories.

19. Applicability to non-traditional Plans

The proposed regulations and the SBC templates assume that all plans are alike. As a result the SBC rules reflect a rigid, one-size-fits-all approach. Section 2715 of the PHS Act directs the Departments, in consultation with the NAIC, to develop standards for a “summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage.” The current SBC templates and the rigid requirements for their completion do not lend themselves to accurately describing the benefits and coverage under non-traditional group health plans such as limited benefit plans and executive medical plans. For example:

- In the case of executive medical plans which are designed to supplement a core benefit plan by covering all out-of-pocket medical expenses, a number of the questions on page 1 on the template (e.g., those related to deductible and out-of-pocket limits) are not relevant, the cost-share categories on pages 2 and 3 are not relevant (there is no cost-sharing), and the examples on page 5 are for traditional medical coverage and do not portray how the executive medical plan would reimburse out-of-pocket medical expenses.

- The SBC templates pose similar difficulties for health insurance issuers offering limited benefit plans. Cigna's insured limited medical plans have neither an overall annual limit nor deductible and in some cases the benefits are limited on a per occurrence basis. The current template does not provide the flexibility to accurately describe the range of benefits approved under the annual limits waiver. Ensuring that individuals understand the limited nature of their coverage is a principal focus of health insurance issuers in connection with their limited benefit plan offerings. We are concerned that force-fitting limited benefit plans into the one-size-fits-all SBC templates will only thwart efforts to ensure that individuals understand the scope of their coverage and benefits.

Health insurance issuers and group health plans need the flexibility in preparing the SBC to ensure that the objective of “accurately describing the benefits and coverage” is realized.

20. Special Accommodations for Expatriate Health Plans

We appreciate the acknowledgment in the Preamble to the proposed regulation regarding the unique characteristics of expatriate and international health plans. In recognition of those unique characteristics, Cigna urges that expatriate and international plans be exempt from these and all requirements of the Affordable Care Act for the following reasons:

Employers with globally mobile workforces typically sponsor a single international plan to cover their expatriate employees. Usually there is not a choice of insurers, nor cost-sharing options. Instead, the employee chooses only whether to include a type of dependent coverage. Accordingly, a comparison of plans at time of enrollment is unnecessary. The utility of the SBC in this context is doubtful.

As indicated previously, Cigna is concerned that the proposed regulations do not build on nor leverage the significant investments that we and group health plans have already made in communicating the terms of international coverage via highly customized materials tailored for globally mobile employees. Our concerns regarding the redundancy, doubtful value and cost of the SBC are heightened exponentially in the context of international health plans for the following reasons:

- The cost of care differs significantly from country to country; cost estimates for health services in the US are entirely unsuitable and confusing to globally mobile employees. Additionally, it is not uncommon for providers outside the US to require up front payment for health care services and reimbursement is

made directly to the customer/member by the insurer. The rigid summary format does not allocate space to reflect this coverage example.

- Forms and terms referenced in the summary are US-centric; they are not applicable outside of the US nor understood by non-US employees covered by the expatriate or international plan. For example, on page 6, the summary states sample care costs are based on national averages supplied to HHS. Clearly, US based national averages will not be a valid estimate of costs incurred outside the US. Populating the Summary document with data not reflective of the individual's potential experience undercuts the very purpose of the summary.
- Coverage information that is particularly important to expatriates (e.g., medical evacuation and repatriation benefits and country-appropriate care) is not even contemplated in the SBC and there is no space allocated for this information.
- Some benefits required to be listed in the SBC are illegal or culturally unacceptable in some countries (e.g., certain reproductive services in some Middle Eastern countries; alcohol and substance abuse services in certain countries).
- Language requirements geared to US residents have no applicability to people living and working outside the US and can be confusing to foreign workers on assignment in this country. The requirements for translation of the summary are based on US census information and US residency. These requirements should not apply to expatriate or international plans.
- The additional time and cost of mailing internationally severely hinder an expatriate plan's ability to provide paper summaries to clients and globally mobile customers (i.e., within 7 days of a request). Internet access is not available in all international locations so an internet posting may not be a viable alternative for receiving the summary (e.g., for expatriates in remote or sensitive locations).
- Certain countries prohibit the transmission of materials by foreign corporations to entities or individuals in the country. For example, Cigna is prohibited from sending communications into certain countries in the Middle East, so Cigna's locally registered third party contractor administers plans and interacts with clients and customers on Cigna's behalf.
- In some locations or industries, it may be difficult or impossible for the insurer to deliver the summary. For example, in Cigna's experience with clients in the

defense industry, the client may deliver enrollment materials in locations that are not accessible to Cigna.

Lastly, US-based insurers issuing expatriate and international policies compete with foreign insurers not subject to the ACA and its requirements. Multinational employers have the option of purchasing policies to cover their expatriate employees from both US and foreign insurance companies. Globally mobile individuals similarly have the option of purchasing their insurance in multiple countries. Subjecting international policies issued by US companies to these requirements creates an uneven playing field adversely impacting the ability of US-based insurers to compete in the global marketplace thereby threatening jobs in the United States.

We appreciate your consideration of these comments. Please do not hesitate to contact me if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Edward P. Potanka". The signature is fluid and cursive, with a large initial "E" and "P".

Edward P. Potanka
Vice-President & Assistant
Chief Counsel