January 29, 2020

The Honorable Alex Azar
Secretary, Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

The Honorable Steven Mnuchin
Secretary, Department of Treasury
1500 Pennsylvania Avenue, N.W.
Washington, DC 20220

The Honorable Eugene Scalia
Secretary, Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

RE: CMS–9915–P

Submitted Electronically via www.regulations.gov

Dear Secretaries Azar, Mnuchin and Scalia,

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. We are pleased to have the opportunity to provide comments in response to your request for information titled "Transparency in Coverage" published in the *Federal Register* (Vol. 84, No. 229) on Wednesday, November 27, 2019.

The members of NAHU work daily to help millions of individuals and employers of all sizes purchase, administer, and utilize health insurance coverage. Our association believes the principle of transparency is critical to the future of health reform. Everyone deserves the ability to make responsible and informed decisions about their medical care. People should also be able to obtain the highest-quality medical care at the best possible price. The purchase of healthcare drives one-sixth of our economy, yet most consumers make related decisions with minimal regard to price and quality of care. In some cases, people make decisions without considering the actual necessity of the purchase. Since most individuals have health plan coverage with a predetermined network, their care-selection process has become more about which providers and facilities are in their system rather than which people and institutions are providing high-quality services for the best price.

NAHU appreciates the intent of the proposed rule: to promote consumerism, health, and well-being by providing health plan enrollees with greater access to pricing information and cost-sharing liability before the receipt of healthcare services. However, our expertise lies in the technicalities of health-plan purchasing and administration and the real-world challenges employers face therein. As such, we have

some suggestions as to how this proposal could be improved to meet the needs of consumers, employer plan sponsors, and administrating entities that will have the responsibility of carrying out much of its provisions. A group of more than 50 brokers who serve individual and employer group clients located in every state have contributed their insight. We have organized our comments by section of the proposed rule.

Required DIsclosures to Plan Participants, Beneficiaries or Enrollees

The proposed rule would require all health insurance issuers and all employers that administer group coverage to make detailed cost-sharing information available to plan participants before they incur a claim. Issuers and employer plan sponsors would have to provide an online tool to all plan participants capable of disclosing the following types of personalized information:

- estimated cost-sharing liability for specific procedures and conditions
- the amount of cost-sharing liability a participant has incurred to date relative to their maximum out-of-pocket limit and any deductible
- the negotiated rate the carrier or group plan has agreed to pay an in-network provider for the specific covered service the plan participant is considering
- the maximum reimbursement amount that the carrier or group plan would pay to an out-of-network provider for a particular service
- an explanation of any prerequisite for the person's specific coverage request, such as step therapy or a preauthorization.

Insurers and plan sponsors would also have to provide consumers with a notice warning about balance-billing to explain that the plan is merely providing personalized estimates, and actual costs may vary.

NAHU members believe that all data elements proposed for disclosure would be helpful for consumers to have before the utilization and purchase of health insurance services. However, your departments need to understand that few, if any, private health insurance issuers and administrators of self-funded employer plans currently provide anything like this level of disclosure to plan beneficiaries before the incurrence of a claim. Most major carriers have treatment cost estimators available, but they are basic and not necessarily available for all plan designs. Few regional carriers currently make any cost-estimation data available. Furthermore, the vast majority of data provided via online tools now rely on estimated costs drawn from publicly available sources rather than personal information and circumstances. Some self-funded plans may be able to give beneficiaries more extensive information beforehand, but that is the exception, not the norm.

Issuers and third-party administrators have an underlying infrastructure to draw from when building the proposed disclosure mechanism; the existing preauthorization process does take place before a claim is incurred and involves many of the same data elements this rule targets for disclosure. However, it will

require significant expenditures and human capital investment to expand this existing infrastructure in the way intended by the proposed rule. Currently, the preauthorization process is very limited in scope for most plans, and it does not align perfectly with the online and paper disclosures proposed in this rule. System expansion and modifications of this magnitude will take time to implement, especially if the goal is to build quality, user-friendly systems.

Additionally, it is essential to note that our membership is not aware of any employers that sponsor group coverage arrangements that currently offer their own, self-created, transparency tools to eligible employees. Any devices that group plan sponsors make available now are developed and maintained by either the issuer of their fully insured coverage or the party that administers their self-funded plan. Even with this proposed rule, NAHU does not anticipate any employer plan sponsors will build in-house transparency systems. For all but the very largest of employers or union plans, it would be an impossible task. Employers simply do not have access to the data they would need, and the cost would be prohibitive. Compliance with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) privacy and data security requirements would be complicated too. So, instead of creating disclosure systems, NAHU anticipates that virtually all employer plan sponsors will contract with their issuer or a third-party administrator (TPA) to meet the terms of any final plan price transparency final rule.

NAHU is concerned the rapid implementation timeframe outlined in this proposed rule will put smaller carriers and TPAs at a considerable disadvantage. Smaller entities are far less likely to have the financial reserves and technological resources that will be needed to build and maintain an online system as currently required by the proposed rule. Instead, these entities will likely rely on third-party vendors to develop and maintain the system for them, which will be a costly endeavor. The considerable disparity this rule may create could give a competitive advantage to larger insurers and bigger TPAs. Not only will small independent service providers be affected, but the employers and employees that currently use their services will as well. If independent smaller carriers and TPAs cannot comply with final transparency requirements, then their employer clients may need to change providers and abandon plan designs and provider networks that currently are serving them well.

NAHU members are not sure how independent TPAs that may incorporate innovative and cost-saving methods like reference-based pricing and direct primary care as part of their services and plan designs will include those into the requirements of the proposed rule. We seek clarification on this point in any final measure. Furthermore, our members are not sure how the proposed rule provisions will work with rental networks and seek clarifying guidance in any final action.

NAHU recognizes that there will always be cost and competitive concerns associated with a proposal like this for smaller entities, and we do not believe those concerns are a reason to not move forward with transparency objectives. However, if there were a more extended implementation period, it could

mitigate the impact on smaller firms. For example, if a final rule was initially limited to the most commonly used CPT codes with an extended implementation window, we believe firms of all sizes would be able to build more effective systems that would benefit all consumers.

Negotiated Rates

The third data element on the proposed rule's list of required disclosures is the negotiated provider payment rate for each requested service. The transparency requirements, as proposed, extend to prescription drug costs. However, the Administration has solicited comments on disclosure requirements related to prescription drugs, including whether a rate other than the negotiated rate, such as the undiscounted price, should be required to be disclosed for prescription drugs. Your Departments have also requested information about whether and how to account for all rebates, discounts, and dispensing fees to ensure individuals have access to meaningful cost-sharing liability estimates for prescription drugs.

NAHU members agree that it would be illustrative for plan participants to learn the undiscounted rate of their prescription drugs, as well as how all rebates work and affect pricing. However, we are not sure that it would be feasible to provide this information on a specific on-demand basis before the adjudication of each claim. Consumers do not need this information ahead of time to make an informed purchasing decision either. What consumers need is for their prescription drug cost estimate to be as accurate as possible, which means that the price quoted to the consumer via the transparency disclosures required in any final rule should include any point-of-sale rebates the consumer could receive. Other data elements, including each covered drug's list price, net price, and negotiated price, as well as any discount, would be more appropriately disclosed in the master file publicly disclosing all plan negotiated rates.

The Departments also solicited comments about scenarios in which drug-pricing information should not be part of an individual's cost-sharing estimate, such as when medications are part of a bundled payment. NAHU members indicate that when a medicine is part of a bundled-payment scenario, then the claim usually is outside of the realm of the retail and specialty pharmacy benefit. Instead, these situations typically arise as part of in-patient or out-patient care. In these cases, the bundled payment disclosure should detail what prescription drugs are in the bundled payment (as well as all other services). However, given that their retail price may not be relevant in an institutional bundled price scenario, it is not necessary to provide that separate and largely irrelevant cost information. In other situations, though, such as the administration of specialty drugs in a hospital setting, it may well be less expensive for consumers to receive their drugs elsewhere, such as in a provider's office or a home setting. If obtaining and administering the medication in another way would yield savings, then that information should be provided to the consumer. NAHU members would like consumers to be able to see as much useful information as possible, if it could impact their cost-sharing and their personal purchasing decisions.

Finally, you inquired as to whether the current relationship between plans or issuers and pharmacy benefit managers allows plans and issuers to disclose rate information for drugs. Or, would contracts between plans and issuers and pharmacy benefit managers need to be amended to provide a sufficient level of transparency? It is the experience of NAHU members that the vast majority of issuers and self-funded plans carve out their retail and specialty pharmacy benefits from the rest of their plan design and administration. As such, all related contracts would need to be amended. Few, if any, current contractual relationships would allow for the disclosures required by this proposed rule. Additionally, a significant implementation window of at least a year will be necessary to achieve the described objectives.

Disclosure Notice

As the Departments note, many states have already addressed balance-billing, and many more plan to address this issue during the 2020 legislative season. Your admission in the preamble to the proposed rule that the balance-billing information in the proposed required disclosure notice "may be misleading or inaccurate for beneficiaries, participants, or enrollees enrolled in a plan or coverage in certain states" is concerning. Given the multi-state nature of most employer-sponsored plans and issuers, we urge the Departments to remedy this issue in any final rulemaking and model disclosure notice template.

In the preamble, you also inquire if the Departments should require a notice that explains that the cost-sharing information provided may not account for claims an individual has submitted, but are not yet processed. NAHU members believe that this is a necessary clarification, and the model notice language should reflect it. Additionally, we feel that if an individual requests cost information on excluded services or treatments, that information also needs to be part of any transparency disclosure to plan participants.

Required Methods for Disclosing Information to Participants, Beneficiaries or Enrollees

First Delivery Method: Internet-Based Self-Service Tool

The rule requires issuers and employer plan sponsors to make a self-service tool available on an Internet website for their participants, beneficiaries, or enrollees to use, without a subscription or other fee, to search for cost-sharing information for covered items and services. Individuals would need to be able to search by specific providers or all network providers, and particular services must be searchable by both CPT Code and “standard medical terms.”

NAHU understands the requirement that users be able to search by CPT code since this is how current claims systems function. Existing issuer and TPA payment infrastructures also rely on CPT codes. However, it is doubtful that any typical consumer will know even standard CPT codes. Even providers may not know codes offhand, limiting the utility of this search capability for almost all people who are not using it in the medical setting. Instead, each system’s search capability by standard medical terms will be crucial. To be successful, this type of search system will need to be broad and user-friendly, accommodating an extensive range of consumer inputs/interpretations of what is a standard term. If not,

its utility will be limited. NAHU members also feel that how this search capability works upon first use will be critical for many users. Users may spurn a system that is hard to use and does not accommodate many variations on search terms. Accordingly, NAHU members urge a long implementation window of at least one full plan year so that issuers and claims administrators may develop and beta-test adequate systems.

The preamble of the proposed rule discusses how "standard medical terms" and "user-friendly systems" are not defined in the proposed rule. Your Departments solicit comments as to whether additional guidance is needed to address what type of language and materials could meet those standards. The preamble points plan sponsors and issuers to the federal plain language guidelines, the requirements for a Summary Plan Description's method of presentation at 29 CFR 2520.102–2(a), and general industry standards for guidance when designing and developing their consumer tools. NAHU members believe that these standards are wholly insufficient and additional guidance is essential. Our members deal with required health plan disclosures daily and observe daily the confusion they create for consumers. It is our view that despite the purpose of the law and the best intentions of federal regulators and many business owners, the content, design, and delivery of virtually all current disclosures need significant improvement. The document that is by far the most problematic is the summary plan description. In a proposed rule published in the *Federal Register* on October 23, 2019, titled "Default Electronic Disclosure by Employee Pension Benefit Plans under the Employee Retirement Income Security Act," the Department of Labor requests detailed information from plan sponsors and other stakeholders about the adequacy of required disclosures. They also solicit detailed information about potential improvements. NAHU urges all three of your Departments to reflect on the responses to that proposed rule and request for information when finalizing this proposal and its extensive disclosure requirements.

The proposed rule also seeks comment on whether only requiring disclosure through a website is sufficient, or should any final rule require disclosure through a web-based application or other electronic means as well. NAHU members believe that it is adequate to require just Internet disclosure, as long as the final requirements do not preclude a plan, issuer, or TPA from developing other means of electronic delivery.

Second Delivery Method: Paper Form

In addition to the Internet-based disclosure requirements, the proposed rule requires plan sponsors and issuers to furnish all of the specified disclosure elements to plan participants and their authorized representatives in paper form within two business days and without charging an additional fee. NAHU members believe that the proposed two-day notification timeframe is unrealistic and unreasonable. Each request would require a fully customized response from the issuer or TPA, which will take time to prepare and deliver. At a minimum, our members believe a 10-day window is necessary. We suggest that the Departments examine other notification requirement timeframes to craft reasonable standards. For example, timeframe requirements for prompt payment and claims adjudication could be a related

reference for the Departments to use. Additionally, we believe that any final rule should place a timeframe as to when the required notice must be created and sent rather than delivered, as mail delivery times are out of an issuer or plan sponsor's control.

NAHU members also believe that any final rule needs significant clarification about requirements for both the inputs and outputs to handle these requests. Each entity would need to set up a system for processing them. A phone system would likely be required and could probably manage most inquiries, but the proposed rule does not permit disclosure of information to just be by phone. This stipulation complicates matters and will increase costs significantly. Additionally, NAHU members anticipate paper and fax requests could occur, mainly through individuals who are seeking information in tandem with a provider during a patient-care setting.

Placing limits on required inputs would make compliance more manageable on a global scale. Eliminating paper requests would reduce costs and administrative burdens. Where providers are concerned, perhaps systems could be integrated with, and limited to, the existing preauthorization process. The proposed rule also does not specify how to record receipt of the request for processing timeframe purposes, so NAHU requests clarification on that point in the final rule.

NAHU members believe that the proposed mailing requirements will be very costly and burdensome, particularly for smaller TPAs. Issuers and TPAs will need to develop extensive infrastructures to accommodate this requirement. Yet by the Departments' estimate, only one percent of people will submit alternative requests rather than using the online system. If this is true, then perhaps there should be limits on paper responses or an allowance for this standard to be met via toll-free telephone interaction. Otherwise, this requirement will cost a great deal and create a significant compliance burden but benefit very few consumers directly.

Special Rule to Prevent Unnecessary Duplication

According to the proposed rule, both group health plan sponsors and health insurance issuers have responsibility for disclosing the information required by this proposed rule. However, businesses with fully insured coverage may shift compliance responsibility and liability to their health insurance issuer via a contractual agreement. Self-funded plan sponsors (including seemingly those with level-funded arrangements, individual coverage health reimbursement arrangements (ICHRAs), qualified small employer health reimbursement arrangements (QSEHRAs), and flexible spending accounts (FSAs) that are not fully integrated with other group major medical coverage) could hire their claims-paying entity or another vendor to help them meet the requirements of the rule, but would still retain ultimate liability. Similarly, health insurance issuers could employ vendors to help them provide transparency tools and data to consumers but ultimately would be responsible for the quality of any work done by a third-party.

NAHU seeks direct clarification in any final rule about the responsibility of employer plan sponsors that offer the following types of coverage to employees: (1) level-funded arrangements; (2) ICHRAs; (3) qualified small employer HRAs; and (4) FSAs that are not fully integrated with group major medical coverage. These funding arrangements do not appear to be covered by the exemptions and duplication of services requirements outlined in the proposed rule. We also seek clarification of the liability of individual employers concerning Multiple Employer Welfare Arrangements and Taft-Hartley plans.

Additionally, NAHU urges the Departments to reconsider the assignment of direct liability to employer plan sponsors in any final rule. Specifically, we believe employer plan sponsors that offer any form of self-funded coverage arrangement should be able to assign liability to a third-party administrator contractually. Employer plan sponsors cannot comply with the requirements outlined in this proposal without the direct assistance of their third-party claims payer and likely other vendors. Plan sponsors do not have direct access to the data and the processes behind claims payment, price negotiation, and administration for their plans; they contract out work that in virtually all circumstances. Employers have no means to exert quality control in these areas, and their compliance outcome will be entirely reliant on their administrating entity, which is not providing insurance. Therefore, NAHU members believe that employer plan sponsors should be able to be contractually transferred to the network negotiator and claims administrator.

Privacy, Security and Accessibility

NAHU appreciates the specification in the proposed rule that nothing in the measure exempts covered entities and business associates from their privacy and data security obligations outlined in the HIPAA and HITECH privacy and data security final rules. While we certainly see the need for greater transparency, NAHU members have concerns about potential violations related to implementation and compliance with this proposed measure. We believe that all entities need to be made aware of their existing privacy and data-security responsibilities and that states and federal regulators need to be diligent about compliance and enforcement. Furthermore, we believe it is important to note that employers, TPAs, and carriers may incur increased costs relative to complying with this measure regarding potential data breaches, increased liability, and cyber-coverage costs that could impact plan premiums.

Proposed Requirements for Public Disclosure of Negotiated Rates and Historical Allowed Amount Data for Covered Items and Services from out of-Network Providers

NAHU members have some concerns about the mandatory disclosure of all charges for covered items and services as negotiated by third-party payers in a master public file, as proposed in the rule. We join in the objections that many other entities have and will raise concerning the appropriateness and anti-competitive nature of a requirement to disclose all negotiated rates in mass form rather than concerning specific transparency requests. NAHU has concerns that the disclosure requirement, as proposed, will

create an unsustainable price floor rather than a ceiling, and requests that the Departments address this concern in any final rule.

Additionally, we note that employer plan sponsors do not have any direct access to or the ability to post or update this rate information or claims data. The coverage issuer or third-party network negotiators and claims administrators are the only entities that could responsibly ensure compliance with this section of the proposed rule. We request that liability for compliance be assigned accordingly.

Request for Information: Disclosure of Pricing Information through a Standards-Based API

According to the proposed rule, your departments are considering whether to require, through future rulemaking, that group health plans and health insurance issuers publicly disclose the price-information elements, negotiated rates and historical claims data addressed in this proposal through machine-readable files known as "standards-based APIs." The goal would be to facilitate uniform use and data sharing in a secure, standardized way. Your Departments believe it could lead to third-parties incorporating the data into applications used by healthcare consumers or into electronic medical records for point-of-care decision-making and referral opportunities by clinicians. NAHU appreciates and understands this point of view and the potential consumer benefits. However, we have concerns about possible violations related to implementation and compliance with this proposed measure. We believe that all entities need to be made aware of their existing privacy and data-security responsibilities and that states and federal regulators need to be diligent about compliance and enforcement. Our membership also has concerns about the potential transfer of protected health information to entities who are not bound by the HIPAA and HITECH privacy and data-security requirements. We recommend that your Departments further address this issue in any final rulemaking, including related consumer disclosures and alternative protections.

Request for Information: Provider Quality Measurement and Reporting in the Private Health Insurance Market

Based on the request for information in this section of the proposed rule, NAHU members have prepared the following answers to the questions posed in your request for information about quality information reporting issues:

1. Whether, in addition to the price transparency requirements the Departments propose in these rules, the Departments should also impose conditions for the disclosure of quality information for providers of healthcare items and services.

   Yes, NAHU members strongly support requiring the disclosure of provider quality information. Bending the cost curve is critical to ensure access to care long term. However, the cost of

service should only be one factor in a consumer's informed decision about provider and hospital selection. Price information must be coupled with quality data if consumers are indeed to have the ability to compare services and make educated and informed purchasing decisions. Beyond that, consumers need additional education and resources to help them determine the weight to give the price, quality, and other factors when making specific medical care choices. NAHU members also believe that pairing quality data with price data improves the utility of consumer price-transparency tools, including what is proposed by this rule.

2. Whether healthcare provider quality reporting and disclosure should be standardized across plans and issuers or if plans and issuers should have the flexibility to include provider quality information that is based on metrics of their choosing or state-mandated measures.

   NAHU believes that, ideally, standard measures should be used, or at least a menu of standard measures, to provide both consumers and plans with consistency. There must be accommodation for state-mandated metrics as well. NAHU anticipates that quality metric reporting will generate a distinct rulemaking process and that additional data can be gathered and provided at that time.

3. What type of existing quality of healthcare information would be most beneficial to beneficiaries, participants, and enrollees in the individual and group markets? How can plans and issuers best enable individuals to use healthcare-quality information in conjunction with cost-sharing details in their decision making before or at the time service is sought?

   NAHU members believe that consumers need educational resources when it comes to assessing provider quality, as many do not feel qualified to judge based on the current metrics at their disposal. NAHU also feels that with more provider quality data, plan sponsors and issuers will be able to design behind-the-scenes cost controls and create better consumer-engagement tools to scaffold and incent more informed patient decision-making.

4. Would it be feasible to use healthcare-quality information from existing CMS quality reporting programs, such as the Medicare Quality Payment Program (QPP) or the Quality Measures Inventory (QMI) for in-network providers in the individual and group markets? Could the quality of healthcare information from state-mandated quality reporting initiatives or quality reporting initiatives by nationally recognized accrediting entities, such as NCQA, URAC, The Joint Commission, and NQF, be used to help participants, beneficiaries, and enrollees meaningfully assess healthcare provider options?

   NAHU supports the use of existing quality data from both CMS sources and recognized quality-reporting initiatives, including information from nationally recognized accreditation agencies,

as a first step toward providing consumers with comprehensive healthcare quality assessment tools.

5. What gaps are there in current measures and reporting as it relates to healthcare services and items in the individual and group markets? The Departments are also interested in understanding any limitations plans and issuers might have in reporting on in-network provider quality in the individual and group markets.

   Currently, there is no standardized reporting of quality data in the individual and group health insurance markets. To mitigate liability and ensure that individual and group plan sponsors have access to the data, NAHU suggests the use of standardized quality measures.

6. The Departments seek more information about how and if quality data is currently used within plans' and issuers' provider directories and cost-estimator tools. The Departments also seek information on the data sources for quality information and whether plans and issuers are using internal claims data or publicly available data.

   Right now, health plan participants do not have consistent access to quality data, and when they do, participants do not consistently use the accessible data either. Carriers that display quality data tend to use publicly available sources, as well as network standards. While not prevalent in the fully insured market, some plans offer enrollees incentives to use certain providers that meet quality and value metrics.

   Our members report that plan beneficiaries often place much trust in what is essentially a broken system. They rely on carriers to exercise quality control via network design, and they rely on primary care providers to refer them to excellent specialists and hospitals. In many cases, primary care doctors provide adequate referrals, but consumers have no means of quality verification. Also, it is our observation that many consumers would prefer to rely on the recommendation of a trusted provider since they do not feel capable of making a judgment with the current degree of quality assessment resources at their disposal. NAHU believes that requiring greater public availability of quality data will help guide the development of tools that consumers might use during the initial choice of a facility or provider. It will also allow health plans to develop better networks, contracting terms, and plan designs for consumers.

Overview of the Proposed Rule Regarding Issuer Use of Premium Revenue under the Medical Loss Ratio Program: Reporting and Rebate Requirements

NAHU members support the concept outlined in Section Five of the proposed rule. This section allows for medical loss ratio (MLR) relief for insurance carriers that offer to fully insured consumers innovative

plan designs that reward people for taking advantage of lower-cost, higher-quality medical services through the use of price transparency tools. We look forward to additional rulemaking and sub-regulatory guidance that details how this proposal would work in practice.

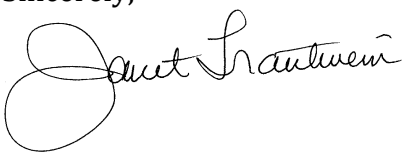
Beyond the MLR relief proposed for new value-based plan innovation, however, NAHU urges your Departments to consider how the new healthcare-transparency tools introduced in this rule will apply to the MLR calculation for fully insured plans. Building and sustaining the required technology proposed in this measure will be expensive, requiring both direct expenditures and investment in human capital. The written disclosure process and the regular disclosure of claims data will also require much time and money. If these development and maintenance costs are deemed purely administrative, we anticipate that the resources that are devoted to development will be limited, with long-term consequences for consumers.

Given that the intent of these requirements is purely to improve consumer access to quality healthcare, NAHU urges you to ensure that expenses associated with creating and operating the disclosure mechanisms proposed in this rule will be a quality expense for the MLR calculation. Otherwise, fully insured carriers will likely need to raise premiums to account for the increased infrastructure costs and liabilities associated with the requirements in this proposed rule, potentially negating any cost savings that the measure could otherwise achieve for plan participants.

Conclusion

The members of NAHU sincerely appreciate the opportunity to provide information to you about the proposed health plan transparency requirements. If you have any questions about our comments, or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0787 or jtrautwein@nahu.org.

Sincerely,



Janet Stokes Trautwein
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