

October 8, 2011

Commissioner Sandy Praeger, Members of the NAIC B Committee

RE: REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZED REBATE CALCULATION METHODOLOGY FOR PLAN YEARS 2011, 2012 AND 2013 PER SECTION 2718 (b) OF THE PUBLIC HEALTH SERVICE

VIA ELECTRONIC MAIL

Dear Commissioner Praeger, Members of the NAIC B Committee:

The Consumer Representatives to the NAIC, representing millions of patients, consumers and workers, are writing to comment on the Regulation for Uniform Definitions and Standardized Rebate Calculation Methodology for Plan Years 2011, 2012, and 2013 per Section 2718 of the Public Health Services Act proposed by the Life and Health Actuarial Task Force based on the proposal of the PPACA Actuarial Subgroup. We are writing to express our support for the work of the Subgroup, which has worked tirelessly over the past five months to complete this proposed regulation, and to urge adoption of the proposed regulation as written. We have filed numerous detailed comments earlier on many issues raised by the regulation and on issues raised by the Supplemental Health Care Exhibit blank that it incorporates. We assume that you have access to these, but would be pleased to provide you with copies if you do not have them.

We have greatly appreciated the leadership provided by Steven Ostlund and the PPACA Actuarial Subgroup in what has been a long, complicated, and controversial process. We as consumer representatives have spent many dozens of hours on conference calls over the past months and many more hours drafting, circulating, and reviewing comments to be submitted regarding issues raised on these calls. The Subgroup has resolved many contentious and difficult issues over these weeks. The process has consistently been inclusive, participatory, thoughtful, and scrupulously attentive to the intent of Congress in drafting 2718. Mr. Ostlund and the Subgroup members have been unfailingly patient and gracious in helping all participants, including consumer representatives, to understand the positions the Subgroup has taken. They have also been fair and impartial in considering the concerns of all parties involved in the process. Their recommendations were accepted without changes by the Accident and Health Working Group (AHWG) and the Life and Health Actuarial Task Force (LHATF). The Regulation incorporates definitions from the Supplemental Health Care Exhibit blank that in turn were adopted unanimously by the NAIC Executive and Plenary in Seattle after a similarly inclusive, participatory, and thoughtful process conducted by Lou Felice and the Health Reform Solvency Impact (E) Subgroup. We believe that the results of these processes within the NAIC are on the whole reasonable, and urge the NAIC to hold to these decisions.

We would discourage the B Committee from modifying any of the recommendations of the Subgroup and any of the decisions reached by the NAIC Executive and Plenary in Seattle.

Indeed, we believe that the regulations should be accepted as drafted.¹ The Subgroup proposal is a carefully crafted compromise. No one group of interested parties—and certainly not consumer representatives—is completely satisfied with the result or got everything it wanted in the process. We refer you again to our earlier comments which identify issues where the Subgroup rejected our proposals. The Subgroup worked collaboratively, however, to achieve a balanced process. Although individual requests of industry and of other interested parties may seem reasonable on their face, changes in the current recommendations that are not offset by corresponding changes favoring consumers will upset a delicate balance. Such changes would be like pulling a thread from a carefully woven fabric.

As we reach the end of the Regulation drafting process, it may be useful to return to basic principles. Section 2718 of the ACA does not say that insurers are entitled to 15 or 20 percent of premiums (plus their investment income) for their administrative expenses, to which will be added the cost of anything they do that is of value to their enrollees or that pursues a valid health policy goal, including goals endorsed by the ACA. Rather section 2718 says that insurance *consumers* are entitled to have 80 or 85 percent of their premiums spent on clinical health care services, and that the cost of activities that improve health care quality can be counted against that 80 or 85 percent. There are many things that insurers do that are worthwhile and add value for their enrollees and to society. Fighting fraud, controlling costs, discouraging excessive utilization, making certain that providers are qualified, seeking accreditation, coding using ICD-10, and improving public health—these are all valid activities. Indeed, they some are activities that are endorsed at various places in the ACA. But, as the NAIC Executive Committee/Plenary have recognized, Congress defined the “quality improvement activities” that insurers may count against the medical loss ratio in section 2717 of the PHSA. These activities—plus payments for clinical services—are the only activities that section 2718 says can be paid for out of the 80 or 85 percent of premiums allocated to consumers.

Insurers have argued over and over again in these proceedings that these activities should be paid for out of the 80 or 85 percent to which consumers are entitled for clinical services and quality improvement costs. At points they even seemed to say that if they had to pay for these activities out of their 15 or 20 percent they would stop doing them. Many of these activities are legally required, others are demanded by employers, others are simply best practices—the mark of a quality health insurance product. But they are not activities that fit within the definition of 2718 or within its purpose, which is to ensure that consumers receive value for their premium payments. The NAIC Executive Committee/Plenary recognized this unanimously at its August meeting. We oppose changes to the regulation that would allow their cost to be counted against the MLR.

We now address specific issues raised in this process:

- We endorse the Regulation’s requirement that MLRs be calculated at the entity, state, and market segment (large group, small group, and individual). Indeed, this result is compelled by the ACA. Section 2718 applies to “health insurance issuers.” The

¹ Two possible exceptions are the treatment of federal taxes and the definitions of small and large group, which are discussed at the end of this document and also in a separate memo.

PHSA defines "health insurance issuer" to mean "an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance **in a State** and which is subject to State law which regulates insurance."

Moreover, section 2718(b)(1)(A) permits states to set medical loss ratio thresholds at levels above the 80 and 85 percent levels set by section 2718, and provides:

In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

It would make no sense to give states discretion as to increasing target percentages if MLRs are to be computed at the national holding company level. Moreover, a clear concern of Congress in adopting section 2718 was that enrollees in states with high MLRs not subsidize inefficient insurers in states with low MLRs. Similarly, there should be no subsidization between different insurance companies or market segments. The result reached by the Subgroup is the result that Congress intended, and should not be changed by the B Committee.

Furthermore, health insurance rate regulation is done at the state level, separately for each insurance company, and also for each market segment (large group, small group, and individual). The expected MLRs are a direct function of the rate process. Therefore, as a practical matter, the logical basis for calculating MLRs is on the same basis by which health insurance rates are determined. The proposed regulation is consistent with the actual procedure for calculating health insurance rates.

- We support the decision of the NAIC, reached unanimously in Seattle, and incorporated into the regulation, to include producers' commissions as part of the premium and as administrative expenses. It is clear that Congress intended agent/broker commissions to be counted as administrative costs for purposes of the MLR. On December 20, 2009, hours before the Senate passed PPACA, Senator Nelson, the former insurance commissioner of Florida, explaining how the legislation made health insurance more affordable, stated on the Senate floor:

I want to give one specific example. It is a technical term in the insurance industry called the "medical loss ratio." It is the ratio in what an insurance company actually pays out in medical claims as opposed to what it pays for administrative expenses such as marketing, insurance agent commissions, underwriting, and an insurance company's profit. . . . What this amendment . . . says, is it causes a specific ratio so you are getting a high amount of return on the insurance premium dollar. . . . And the balance, . . . is going to things such as administrative expenses, paying for insurance agents, commissions, paying for their profit. . .

155 Cong. Rec. S13558, S13626-S13627.

Moreover, the clear wording of ACA precludes the exclusion of commissions. Section 2718(a)(3) discusses, “all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.” If Congress wanted to exclude commissions from “all other non-claims costs” they could have done so. The fact that Congress did not, while excluding other items, clearly shows that for purposes of the MLR calculation, commissions must be treated the same as any other non-claims cost.

Section 1301(a)(1)(C)(iii) of the ACA states that the issuer of a qualified health plan must agree “to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent.” Obviously Congress understood that agent/broker commissions were part of the premium rate charged by health insurers. We support the NAIC in maintaining this position.

Excluding commissions from premiums would also dramatically increase the portion of the premium available to insurers for their other administrative costs. Congress set the target MLR percentages at 80 percent for the individual and small group market and at 85 percent in the large group market, and the CBO accepted these percentages, under the assumption that producer commissions were included. It would have set the percentages higher had it assumed they were excluded. Moreover, insurers have throughout the Subgroup process assumed producers’ commissions were included in the MLR. It is the primary reason why they have argued that transitional adjustments to the MLRs are necessary.

Treating commissions the same as the other overhead expenses of insurance companies is consistent with the manner in which financial statements are required to be submitted to the NAIC. In the Annual Statement filed by Life Insurance Companies, in both the Summary of Operations (Page 4) and the Analysis of Operation by Lines of Business (Page 6), commissions (Lines 21 and 22) are treated in exactly the same manner as general expenses (Line 23) in determining the net gain from operations (Line 29). Hence, the NAIC has previously made the determination that for the purpose of financial reporting and analysis, commissions should be treated in the exact same manner as any other insurance company overhead expense. This same procedure should be used for financial reporting and analysis in the MLR calculation.

Agents and Brokers have argued that commissions are a pass-through fee and hence should not be included in the MLR calculation. That argument is completely without merit. From the point of view of the consumer, it does not matter what entity ends up with a portion of the premium. The issue to the consumer, and to Congress, is how much of the premium goes toward “reimbursement for clinical services provided to enrollees under such coverage [and] for activities that improve health care quality”. Commissions simply do not fall into either of those categories. It should also be remembered that agents work for insurance companies. Furthermore, for many

consumers, there is no difference between the agent and the insurance company. They are considered the same entity.

Finally, it is generally accepted in the insurance industry that commissions are part of premiums. The National Association of Health Underwriters website gives the following definition of Commission²:

Commission: Part of an insurance premium, which is paid by an insurance company to an agent or broker for procuring and servicing the business for the insurance company/client. Depending upon the size of the group being insured, these commissions average between three and ten percent of the premium paid by the employer.

- We strongly support the decision of the NAIC, reached unanimously in Seattle and incorporated into this regulation, to not allow issuers to claim their fraud prevention and detection expenses as quality improvement expenses. Including these expenses as quality improvement expenses would be wholly contrary to the language of the statute and the intent of Congress. Congress was fully aware of the importance of combating health care fraud—an entire title of the ACA is devoted to it—but did not allow consideration of fraud expenses in the MLR.

Insofar as the regulation does allow an offset of fraud prevention expenses against recoveries, we are concerned that insurers not be allowed to claim any money spent on utilization review or claims audits that result in recoveries of overpayments as fraud detection and recovery expenses. We believe that clear definitions are needed to assure that they do not. We urge the B Committee to tighten the definition of fraud.

- We endorse the decision of the NAIC, reached unanimously in Seattle and incorporated into this regulation, to not include the costs of the ICD-10 conversion as a quality expense, but rather to track them for HHS for further consideration in the future. Insurers are changing from ICD-9 to ICD-10 as part of a worldwide change in coding standards, one mandated of providers by CMS. ICD-10 coding may make it easier to track quality activities, but it is fatuous to contend that the change is itself a quality of care activity. Had the ACA never been adopted or not included section 2718, insurers would still be adopting ICD-10.

Moreover, while the industry talks only about costs of implementing ICD-10, they do not mention (or account for) savings, e.g., in lower payments to providers through better tracking of services actually delivered, reduced ability to "pad" charges, reduced claims paid, fewer fraudulent claims, and more accurate processing of claims and therefore fewer rejected claims. If the insurers had to report their net costs of the conversion, it is likely there would be none. Businesses adopt these types of cost containment activities to lower costs on a net basis.

² <http://www.nahu.org/consumer/glossary.cfm#C>

- We strongly support the decision, reached unanimously in Seattle and incorporated into this regulation, to identify concurrent and retrospective utilization review, provider contracting, and network management costs as cost control and not quality improvement activities. No doubt these activities have some effect on quality. But they are fundamentally administrative activities and should remain classified as such. Insofar as these activities can be identified as case management, disease management, care coordination, or discharge planning activities related to quality they are already covered under the blank.
- We continue to support the decision of the NAIC, reached unanimously in Seattle and incorporated into this regulation, that taxes on investment income not be subtracted from the denominator. Investment income, which for some insurers is a major source of revenue, is nowhere considered in the MLR formula, which only counts premium revenue. It would be grossly unfair to allow insurers to subtract these taxes from their premium revenue while not having to account for the investment income on which these taxes are based. Moreover, section 2718 provides that taxes are excluded from premium revenue. Taxes not attributable to premium revenue cannot be excluded from it, therefore section 2718 prohibits subtraction of taxes on investment income. The industry's argument that the federal tax exclusion extends to all taxes they pay, including taxes on investment income, would seem to mean that the taxes that insurers pay on premiums from other lines of business should also be subtracted from health insurance premium revenue. This simply cannot be what Congress intended. Only taxes on premium revenue should be excluded, not other taxes paid by insurers. (Alternatively, investment income should be considered premium revenue, since its ultimate source is premiums, and be counted in the denominator).
- We continue to support the approach of the NAIC, adopted unanimously in Seattle and made part of this regulation, to handle the addition of new proposals for quality of care expenses by requiring explicit proposals to be approved by the NAIC and certified by HHS. Earlier proposals that would have permitted the addition of new categories without an explicit review process would be unworkable and open to serious abuse.
- We support the decision of the NAIC, reached unanimously in Seattle and incorporated into the regulation, to allow insurers to count the monitoring, measuring and reporting costs that they incur for maintaining accreditation and for reporting HEDIS and CAHPS data as quality improvement expenses, but not accreditation fees. The National Committee for Quality Assurance (NCQA) accreditation, for example is based on six categories of accreditation standards:
 - Quality management and improvement,
 - Utilization management,
 - Credentialing and recredentialing,
 - Members' Rights and Responsibilities,
 - Standards for Members Connections, and
 - HEDIS/CAHPS performance measures.

While HEDIS and CAHPS and quality measurement and reporting facilitate quality improvement, the remaining standards are intended to assure the quality of the insurance product, not of health care. All of the issues accreditation addresses are important to consumers, but not all are related to improving health care. It is appropriate that insurers be able to claim monitoring, measuring, and reporting costs related to accreditation, but it is not appropriate to including accreditation fees as quality improvement expenses.

- We support the Subgroup’s approach to dealing with the credibility of reported MLR experience for small insurers. Small insurers offer consumers choice and provide competition for larger insurers. The credibility adjustments applied by the regulation should allow small insurers to continue to offer their products to insurers. It must be recognized, however, that the credibility adjustments are substantial—up to 14 percent³ for the smallest insurers—and will be applied to virtually all insurers in many states. It is important, therefore, to underscore the following:
 - The credibility adjustments should not unduly inflate the reported MLR experience of insurers. We therefore would oppose increasing the credibility adjustments above the levels derived by Milliman after extensive analysis and study, which were adopted by the Subgroup.
 - Experience should be carried forward from year to year and rebates should be paid based upon actual reported experience without a credibility adjustment if an insurer consistently fails to achieve the target percentage over a three year period. Otherwise an insurer could consciously aim for a MLR level below the target level and would face no consequences for doing so, contrary to the intent of Congress.⁴
 - MLR rebates in previous years should not be subtracted from the indicated rebate for the current year based upon an aggregation of multiyear experience. The MLR calculation is set up so that each year stands on its own. The process is as follows: for each rebate year (i) an MLR is calculated, (ii) a credibility adjustment, if applicable, is made, (iii) the credibility adjusted loss ratio is compared to the target loss ratio and (iv) to the extent the target loss ratio exceeds the credibility adjusted value, that difference is multiplied by the premium (excluding applicable taxes and fees) for that *one year* in order to determine the rebate payable for that one year. Hence, the rebate calculation payable in each year stands on its own⁵, and there is no need or basis for subtracting out rebates paid in prior years. While it is possible that other procedures could have been used to calculate rebates, the method set forth in

³ 14.4% = 8.3% (Table 1 Additive Adjustment) X 1.736 (Table 2 Adjustment Factor)

⁴ Technical details discussing how an insurance company that targeted an MLR below the Section 2718(b) levels would pay too low of a rebate are discussed in a June 30, 2010 memo from Allan Schwartz (the actuarial advisor to the Consumer Representatives) of AIS Risk Consultants to Steve Oslund.

⁵ Even though the rebate calculation for each year stands on its own, the details of the calculation of the rebate for that one year may reflect the loss ratio experience in other years either because of credibility considerations or the requirements of ACA.

the regulation is reasonable, actuarially sound and should be adopted. The insurance industry may argue that the method in the regulation is biased towards calculating inflated rebates. We strenuously disagree. In fact, in the example presented by NAIC staff⁶ in connection with the September 15 Conference Call, the method in the regulation gives a lower rebate than an alternate method where prior rebates are subtracted out. Hence, alternate rebate formulas that are different than those contained in the proposed regulation may sometimes give a higher indicated rebate and sometimes a lower indicated rebate, but there is no inherent bias one way or another. Finally, Richard Diamond on behalf of the PPACA Actuarial Subgroup of the AHWG, prepared a memo dated September 24, 2010 in which he considered in detail the arguments presented by the insurance industry; and he concluded that the rebate formula in the regulation is appropriate. For all these reasons the NAIC should not change the rebate formula calculation as set forth in the proposed regulation.

- We oppose making further accommodation in the form of exceptions for “different” types of plans in the proposed rule unless the exception is fully justified by the evidence. We recognize that 2718(b) allows the NAIC to “take into account the special circumstances of smaller plans, different types of plans, and newer plans,” in establishing the methodology for calculating MLRs. The Subgroup has done so in the credibility adjustments and in dealing with certain employer plans and with new insurers. We understand that mini-med plans would also like to be subject to a different methodology than other plans. We expect other types of insurers will ask for special treatment as well. We would oppose any modification in the methodology that is not supported by hard evidence as to existing MLRs, the special circumstances of particular insurers that make it impossible for them to achieve the MLRs, what adjustment to the general methodology is necessary to accommodate those circumstances and what process will be implemented to move the loss ratio up to (or at least closer to) the Section 2718(b) values. Congress did not intend that this provision be used as a dispensation for granting waivers to plans just because they do not currently meet the MLR requirements.

While we believe that the drafting process should not be reopened, if the B Committee does make any adjustments in the proposed regulation, we would request consideration of the following:

- We urge the B Committee to amend the remainder of the definition of federal taxes to be subtracted from the denominator included in the regulation to conform it to congressional intent. The regulation picks up the broad definition of federal taxes included in the Supplemental Health Care Exhibit. After the Health Reform Solvency Impact subgroup finished its work on this blank, however, the NAIC was informed that in fact Congress intended a much more limited definition of federal taxes, including only the new federal taxes imposed on insurers by the ACA, and not the broad definition included by the Solvency Impact subgroup. Unlike the rest of the

⁶ EXCEL File named “MLRRebateFormula0913”

Supplemental Health Care Exhibit, therefore, the tax definition as adopted by the NAIC plenary and included in the regulation was not fully debated through the entire NAIC process with the benefit of full information on congressional intent. The B Committee should, therefore, reconsider this one part of the blank, given the new information. A memorandum from Timothy Jost, examining the language and legislative history of the tax provision in section 2718 is attached. Furthermore, current financial reporting as required by the NAIC recognizes that federal income taxes are separate and distinct from other types of taxes and fees. In the Annual Statement filed by Life Insurance Companies, in both the Summary of Operations (Page 4) and the Analysis of Operation by Lines of Business (Page 6), there are separate lines for “insurance taxes, licenses and fees, excluding federal income taxes” (Line 24) and “federal and foreign income taxes incurred (excluding tax on capital gains) (Line 32). As a first step in determining the “Net Gain from Operations” (Line 29) the financial statement required by the NAIC only subtracts out “insurance taxes, licenses and fees, excluding federal income taxes”. It is only later that federal income taxes are removed to obtain a net gain after taxes. Hence, the NAIC has previously made the determination that for the purpose of financial reporting and analysis, that “insurance taxes, licenses and fees, excluding federal income taxes” are separate and distinct from “federal and foreign income taxes” This provides additional support for not subtracting any federal income taxes from premiums in calculating the MLR and corresponding rebate.

- The Rule at section 3.A.(7) & (10) defines small and large group “as such term is defined in the Public Health Services Act.” These definitions should be amended to read “as such term is defined in the Affordable Care Act.”

Although section 2718 is a section of the Public Health Services Act, it is added to the PHSA by section 1001 of the ACA, which is part of Title I of the ACA. Section 1551 of the ACA states: “Unless specifically provided for otherwise, the definitions contained in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91) shall apply with respect to this title [Title I].” Section 2791(e) of the PHSA defines large group as group insurance offered by a large employer and small group as insurance offered by a small employer. As amended by section 1563(c)(16) the PHSA defines “small employer” as an employer with 100 or fewer employees and “large employer” as an employer with 101 or more employees. But section 1304 of the ACA specifically provides that for purposes of Title I of the ACA, of which Section 2718 is a part, states may prior to 2016 define small employer to as an employer with 50 or fewer employees and large employer with 51 or more. Since the ACA “specifically provides otherwise,” the amended PHSA 2791 definition does not apply.

The NAIC should adopt the ACA definition, because it is what the law requires, because it increases the discretion of the states to deal with their own particular insurance markets, and because it will avoid the situation of groups between 50 and 100 being classified as large groups for most regulatory purposes but as small groups for the MLR calculations.

Finally, although the handling of the transition to the MLRs between 2011 and 2014 is not addressed by the regulation, it is addressed by the statute, which gives HHS the discretion to reduce the MLRs on a state by state basis as necessary to prevent destabilization of the nongroup market. This issue was addressed by IRD041 which is not part of the final regulation. Transitional problems cannot be addressed through the NAIC's authority to define methodologies, as some have suggested, because the statute expressly delegates to HHS the authority to address this problem. IRD041 presents a viable solution to the problem, however. IRD 041 recommends that the Secretary consult with the Insurance Commissioner in each state (and with consumers, insurers, and other interested parties) to decide whether or not to adjust the 80 percent MLR used for the rebates in one or more years after considering if the application of the MLR is likely to destabilize the state's individual insurance market. It urges HHS to consider other characteristics including the number of carriers and actual historical loss ratios of each individual carrier in the state, alternative sources of insurance coverage, and the vulnerability of the market. We urge the B Committee to ensure that HHS receives IRD041 as a recommendation from the NAIC, independent of the regulation.

Congress asked the NAIC to establish the definitions and methodologies for the MLR process because of the NAIC's technical expertise in insurance matters. The Subgroup has done an exceptional job in applying that technical expertise to the difficult questions raised by the MLR process. Even after the NAIC adopts an MLR regulation, the insurance industry will have the opportunity to request that HHS make changes. Therefore, we strongly urge the NAIC to accept the recommendations of the experts from the various state insurance departments who spent countless hours over many months putting together a document that reflects a technically and actuarially sound implementation of the MLR and rebate aspects of ACA. Adopting the proposed regulations will mean that the NAIC performed the job requested by Congress, which was to use its expertise to draft a technically and actuarially sound regulation. If modifications are made for other reasons, the appropriate place for those changes to be made is at HHS.

We continue to appreciate the care with which you have approached this difficult task and the seriousness with which you have taken our concerns and your responsibility under the ACA.

Sincerely,

Timothy Jost
Georgia Maheras
Stephen Finan
Joe Ditré
Sabrina Corlette
Brendan Bridgeland
Wendell Potter
Mark Schoeberl
Bonnie Burns
Elizabeth Abbott
Butch Hollowell
Barbara Yondorf

To: Commissioner Sandy Praeger, Members of the B Committee

From: Timothy Jost, Funded Consumer Representative, Professor, Washington and Lee University School of Law

Re: Interpretation of Public Health Services Act 2718 Regarding the Treatment of Federal Taxes for Purposes of Medical Loss Ratios

The NAIC's Authority to Establish Definitions to Effectuate Congressional Intent Under 2718

Section 2718 of the Public Health Service Act, added by section 1001 of the Patient Protection and Affordable Care Act, sets out a methodology for calculating medical loss ratios and for determining when and in what amount insurers must pay rebates to their enrollees if their medical loss ratios do not meet statutory standards. Section 2718(c) specifically charges the National Association of Insurance Commissioners with the task of defining the terms used in the medical loss ratio formula and establishing the methodology used for computing it.

Since April of this year, two subgroups of the NAIC have been establishing definitions to implement section 2718. In doing so, they have consistently eschewed a literal approach to interpreting the statute, trying practically to effectuate the intent of Congress while accommodating the practical realities of insurance regulation. Thus the Blank drafted by the Health Reform Solvency Impact Subgroup and approved by the E Committee, Executive, and Plenary, allows insurers to offset their fraud recovery expenses against fraud recoveries, even though the word "fraud" does not appear in section 2718. The Blank also allows tax-exempt insurers to deduct community benefit expenses, a deduction not recognized in Section 2718. The Regulation allows insurers to aggregate claims from employer groups in a single location, even though the statute, by cross reference to the Public Health Services Act, requires MLRs to apply to insurers on a state-by-state basis. Time and again insurers have supported definitions that deviate from the literal language of the statute when following the literal language of the statute would be to their disadvantage.

When it comes to federal taxes, however, the insurers have become 2718 fundamentalists. They contend, and have submitted legal opinions arguing, that one, and only one, term in the statute, "federal taxes," must be read literally. It must be read to include all federal taxes. With respect to this one term of the statute, they argue, the NAIC has no definitional discretion. Principles that are applied by courts in interpreting statutes, they argue, must in this single instance be followed by the NAIC, which must, in the face of congressional intent to the contrary, give this term the broadest possible reading, to the benefit of the insurance industry.

The NAIC's discretion is not so limited. Congress explicitly delegated to the NAIC the responsibility of defining the terms in the statute. This discretion explicitly applies not only to the definition of the term "activities that improve health care quality," but to all of

the terms found in Section 2718(a), including the term federal taxes. The heads of the six congressional committees that had jurisdiction over the ACA have clearly stated in their letter of August 10 that their intent in using the term “federal taxes” was only to include the three new taxes imposed on insurers by the ACA. The NAIC should exercise the definitional discretion granted it under the ACA to effectuate this intent. Only the taxes imposed by sections 9010, 6301, and 9001 of the ACA should be entered on line 1.5 of the blank and be excluded from the MLR denominator by the regulation. All other federal taxes should be entered on line 10.3 and counted as administrative costs.

The History of the Federal Tax Provision of Section 2718

Section 2718 was found in H.R. 3590, the original version of the ACA introduced on September 17, 2009. The original version provided for a rebate, as does the current version, but the rebate was based on an insurer’s administrative costs exceeding a threshold rather than on its medical loss falling below a threshold. Federal taxes are nowhere mentioned in this formula, although “state taxes and licensing and regulatory fees” were subtracted from administrative costs before they were divided by premium revenues.

Section 10101 of the manager’s amendment, introduced on December 19, 2009, completely rewrote Section 2718. The Section 2718 rebate formula was changed so that it is now based on the amount that insurers spent on clinical care and activities that improve health care quality—not their administrative costs--divided by premium revenue. Section 10101, defined the denominator as:

the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

The Senate adopted H.R. 3590 on December 23, 2009, and the House three months later. No committee report was adopted by either house. Since the House adopted the Senate bill unamended, there was no conference committee and no conference report. The only extended floor speech on the MLRs, a speech given by Senator Nelson of Florida (155 Cong. Rec. S13558, S13626-S13627), did not address the tax issue. There is thus no pre-enactment evidence of what the term “federal taxes” means.

The only authoritative evidence as to what the term means is that provided by the August 10, 2010, letter from the committee chairs. There is no reasonable basis for contesting their understanding of what they meant in drafting the provision. These congressional leaders, in particular the Senators, played a key role in drafting this provision, and presumably knew what it meant. Unless the insurers are questioning the honesty and integrity of six congressional leaders, they must concede that this is what these leaders intended when they drafted the manager’s amendment less than a year ago.

The Meaning of “Federal Taxes” Is Not Unambiguous

The insurers do not explicitly question the honesty and integrity of these congressional leaders; rather they claim that what the leaders understood the statute to mean is irrelevant. The insurers claim that the words of the statute are unambiguous, and therefore what the drafters intended is of no consequence. They cite a long string of Supreme Court cases reciting its principle. But is the term federal taxes in fact unambiguous?

Does it, for example, include income and capital gains taxes on investment income? Investment income appears nowhere in the Section 2718 formulas, which only include reimbursement for clinical services, quality improvement activities, and other non-claims costs in the numerator, and premium revenue in the denominator. How can taxes on investment income be excluded from premium revenue when investment income was never part of premium revenues? That would be like allowing an insurer to exclude taxes on its property/casualty business, which are technically federal taxes paid by the insurer. What about taxes withheld by the insurer for its employees, including payroll taxes? Are they federal taxes that should reduce the insurer’s premium revenue? Or are they part of compensation and thus part of administrative costs?

Indeed, if one assumes that the committee chairs are not, in fact, lying, the interpretation they place on the term “federal taxes” is perfectly consistent with the use of the term in Section 2718. It may indeed be the most obvious “plain meaning” of the term. First, Section 2718(b)(1)(B)(i)(II) must be read as a whole. Under the manager’s amendment, federal and state taxes are excluded from premium revenue, and thus linked to premium revenue. They are not excluded generally from the income of the insurers. Thus it is reasonable to conclude that premium taxes, and not general income, payroll, or other federal taxes are intended. Second, federal and state taxes are linked with “licensing and regulatory fees.” Under the principle of *noscitur a sociis*, “a word is given more precise content by the neighboring words with which it is associated.” *U.S. v. Williams*, 553 U.S. 285, 294 (2008); *Jarecki v. G.D. Searle & Co.*, 367 U.S. 303, 307 (1961). Coupling federal and state taxes with licensing and regulatory fees indicates that federal and state taxes on premiums, not more general taxes, were intended.

The NAIC Should Define “Federal Taxes” to Effectuate the Intent of Congress

Moreover, as was noted at the outset, Section 2718 explicitly gives the NAIC the authority to define the term “taxes,” and HHS the authority to certify that result. When statutes explicitly delegate explicit authority to define statutory terms, the courts pay considerable deference to agency interpretations. See *Batterson v. Francis*, 432 U.S. 416, 425 (1977) (“In a situation of this kind [where authority to define is expressly delegated], Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term. Exercising that responsibility, the Secretary adopts regulations with legislative effect. A reviewing court is not free to set aside those regulations simply because it would have interpreted the statute in a different

manner.”); *Schweiker v. Gray Panthers*, 453 U.S. 34, 44 (1981) (“In view of this explicit delegation of substantive authority, the Secretary's definition of the term “available” is “entitled to more than mere deference or weight” Rather, the Secretary's definition is entitled to “legislative effect” Although we do not abdicate review in these circumstances, our task is the limited one of ensuring that the Secretary did not “exceed his statutory authority” and that the regulation is not arbitrary or capricious.”) The NAIC need not limit itself to the most obvious and straightforward reading of the word “federal taxes” but should take seriously its responsibility to determine that Congress actually intended the word to mean.

The insurers contend that post-enactment statements are of no value in determining what Congress meant. They cite a number of Supreme Court cases that in fact make this observation. These cases, however, involved attempts to argue that statements made in debates or amendments offered in subsequent Congresses can be used to interpret earlier legislation. None involve a statement signed by the chairs of all jurisdictional committees who sponsored a piece of legislation in the immediate wake of the enactment of the legislation where pre-enactment history of the legislation was completely absent. Indeed, in *District of Columbia v. Heller*, 128 S.Ct. 2783 (2008), one of the cases cited in AHIP’s brief, Justice Scalia (who is famous for his contempt for legislative history generally) relied extensively on post-enactment commentary for interpreting the Second Amendment. Courts obviously prefer pre-enactment legislative history, but they also take post-enactment explanations into account when it is useful to understand congressional intent. *Cannon v. University of Chicago*, 441 U.S. 677, 686, n. 7 (“Although we cannot accord these remarks the weight of contemporary legislative history, we would be remiss if we ignored these [subsequent] authoritative expressions concerning the scope and purpose of Title IX . . .”). In this situation, where the August 10 letter is the only authoritative indication of legislative intent, the NAIC would clearly be remiss to ignore it.

The insurers contend that the fact that 2718 explicitly refers to the sections 1341, 1342, and 1343 in qualifying payments for risk adjustment, risk corridors, and reinsurance which are also excluded from the denominator means that Congress could not have meant to limit federal taxes to the premium taxes included in the ACA, as the congressional letter indicates. There is a certain irony in this position, as in the actuarial subgroup context the industry has argued that the MLR formula should exclude all reinsurance payments, not simply those described in 1341, demonstrating again that the industry takes a literal approach only when it is in its interest. Leaving that aside, however, Congress evidently believed that it was necessary to list these provisions to clarify exactly which reinsurance, risk adjustment, and risk corridor programs it was referring to. Evidently, it believed that associating federal taxes directly with premium revenues and with licensing and regulatory fees sufficiently clarified that it was referring to taxes on premiums, and that the only federal premium taxes in existence were those created by the ACA.

Congress has delegated to the NAIC the responsibility for defining the terms of Section 2718. Heretofore the NAIC has taken a practical approach to this task, trying to interpret the statute to carry out congressional intent. The only evidence that exists of what

Congress meant by “federal taxes” is the letter of August 10, stating authoritatively the intent of those most important to the drafting of this provision. With respect to this one issue, the insurers abandon the interpretive position they have taken throughout these proceedings and argue for an arid literalism: federal taxes means all federal taxes. But it is far from clear that this is the meaning of the term when read in context. The NAIC should interpret “federal taxes” to carry out established congressional intent, limiting it to the premium taxes established by Section 2718.



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CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

THOMAS B. CONSIDINE
Commissioner

October 8, 2010

To Health Insurance and Managed Care (B) Committee Members

Re: Draft Model Regulation for Uniform Definitions and Standardized rebate Calculations Methodology for Plan Years 2011, 2012 and 2013 per section 27188(b) of the Public Health Service Act

Dear Colleagues:

The draft Model Regulation represents substantial progress in meeting the NAIC's statutory obligation under the Affordable Care Act (ACA) to establish uniform definitions and standardized methodologies for calculating rebates. Many talented individuals lent their expertise to the drafting, and it clearly shows. I would, however, like to comment on two areas of concern.

I understand and support the decision to aggregate losses at the legal entity/issue state level as opposed to a national and/or holding company level. Contract issue states and issuing entities are the levels at which the insurance business is regulated, and at which the ACA requires the rebate. Section 2718(b)(1)(A) specifically obligates each insurance 'issuer' to provide the rebate, and acknowledges state authority to regulate the percentage paid. Aggregating losses at the national level would not only go against the spirit and letter of the ACA, but represent one further step toward the federalization of health care regulation, a concept I am sure that is anathema to us all.

Aggregation at the state/entity level as opposed to a national and/or holding company level does, however, increase the likelihood that there will not be sufficient credible claims data on which to base the rebate. The rules also need to support smaller regional plans that do not have sufficient credible claims experience. The ACA specifically directed the NAIC to take into account the special circumstances of smaller plans.

Absent a rebate requirement, insurers with experience that is not fully credible in a single year can expect random negative experience fluctuations in one year to be offset by gains in another. If there is a rebate requirement and credibility is not sufficiently accounted for, the insurer must absorb the years of random bad experience while refunding surplus in years of random gains. This could lead to one or both of the following undesirable consequences: insurers will increase rates, to reduce the likelihood of adverse experience in one year that cannot be offset by gains in another; or insurers will withdraw or restrict marketing in states without critical mass to support. Either result puts smaller plans at a

competitive disadvantage to plans with sufficiently credible in-state experience.

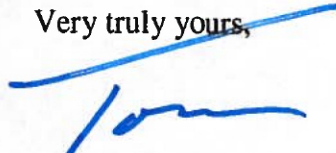
Credibility adjustments therefore become of critical importance. While the draft regulation does provide for such adjustments for plans with less than 75,000 life years, significant concerns have been raised by the industry that the credibility factors and the life-year threshold are too low to stem the potential damage to the marketplace. These concerns should be heard. The Milliman Study upon which the factors are based suggests that a different confidence interval could be used, and that there are sources of variation that are not measured in its study. The American Academy of Actuaries letter of May 12, 2010 modeled credibility adjustments going up to 200,000 average members. Further work should be done in both of these areas. Prudence dictates that we move cautiously here, as this type of marketplace disruption is not easily undone.

Applying the regulation at the state/legal entity level but revising the credibility adjustments to account for greater potential variance in MLRs at the lower tiers strikes a balance between maintaining state-level control and recognizing the impact that has on calculations in states with smaller covered populations. I am of course mindful of the time pressure and do not suggest delay; the Committee can move on the framework for the Model Regulation, deferring recommendation on just the actual credibility factors and size thresholds pending further study.

My second issue is the appropriate payee for the rebate. In a separate letter to Secretary Sebelius, Insurance Commissioners recommended to HHS that rebate payments be made to the individuals or entities that paid the premiums. The draft Model stops short of incorporating this requirement, presumably deferring to the Federal Regulators.

I urge the NAIC to pursue this issue vigorously, and oppose any proposed result that is contrary to the recommendation. The rebate requirement is found in the section of the law entitled "Bringing Down The Cost Of Health Care Coverage", and in the Subsection "Requirement To Provide Value For Premium Payments". Clearly the desired result is that any rebate inure to the benefit of the premium payer, not provide for redistribution of wealth and a windfall for insureds. Any result that would have payment made to anyone other than the premium payer would be irrational, potentially administratively impractical and contrary to the intended result of impacting premiums.

Very truly yours,



Thomas B. Considine
Commissioner



STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

David A. Paterson
Governor

James J. Wrynn
Superintendent

October 11, 2010

Sandy Praeger, Chair
Health Insurance and Managed Care (B) Committee
NAIC
2301 McGee Street,
Suite 800
Kansas City, MO 64108

Dear Commissioner Praeger,

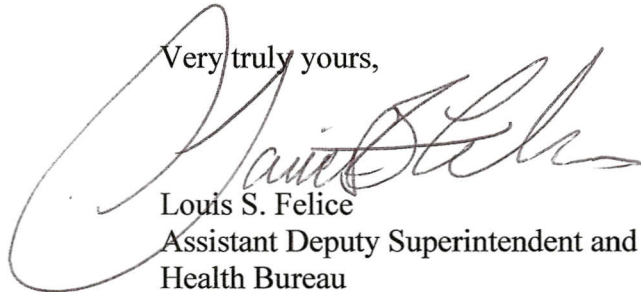
New York is submitting comments on the exposure draft medical loss ratio (MLR) Regulation that was released on October 5, 2010. We can appreciate the many hours that Chairman Steve Ostlund, and the members of the PPACA Subgroup put into developing the draft regulation on medical loss ratios (MLR) within such a tight timeline. New York supports the work product as a consistency benchmark for all States to follow. Particularly we support the conclusion that rebates should be calculated by State and legal entity (with limited exceptions) and without considering reinsurance. However, we do have some concerns about State flexibility and the relationship between this regulation and rating procedures that we believe need to be addressed. We also believe that there needs to be a strong and transparent reconciliation process between the rebate calculation and the E - Health Reform Solvency Impact Subgroup's Blanks proposal. Here are our specific comments:

1. There should be no impact on rating or review of rate adjustment filings resulting from adoption of this regulation. It must be clear that State insurance regulators are under no obligation to measure and approve rates on the basis of the rules for calculating MLR rebates. As an example, a State may require a stricter standard and / or other criteria to evaluate whether a rate adjustment request is reasonable, and would not be bound by a carrier asserting that it rates for the individual, small group or large group products will meet the Federal rebate MLR as the sole reason to approve a rate adjustment.
2. Flexibility must be preserved for States to use rating regions or other rating pools and to administer the MLR rebate so long as the rebate criteria are as stringent as or more stringent than the Regulation. New York strongly supports the concept that if the State applies the underlying credibility adjustments for the rebate aggregation described in the regulation, a lower level of aggregation should be allowed based upon rating regions or other State specific criteria that is used for rating purposes. It is our understanding that application of a higher State specific threshold than the Federal MLR threshold of 80 / 85% is already acceptable.
3. NY does not support the inclusion of claims reserves related to litigation or other contingencies in the MLR calculation unless such treatment is explicitly supported by existing NAIC accounting or reporting guidance. Such reserves can be extremely subjective and can be adjusted from year to year to meet MLR requirements. We believe that only paid claims resulting from litigation, or unpaid claims on settled but not yet finalized litigation only should be included in the MLR calculation in the absence of existing NAIC guidance.

4. We strongly recommend that the Rebate Calculation Supplemental Form in the draft regulation be used to reconcile the claim amounts reported on that form to amounts reported on the Supplemental Health Care Exhibit (Blanks Exhibit) adopted by the NAIC on 8/27/10. Such reconciliation should be made contemporaneously with the rebate calculation and the Rebate Calculation Supplemental Form and as part of that form, rather than requiring a third filing. The E-Health Reform Solvency Impact Subgroup carefully avoided implication that the MLR calculated on the Blanks Exhibit would correspond to the actual rebate calculation. However, transparency in how the numbers on the Blanks Exhibit get translated to a rebate calculation is essential. NY is prepared to suggest information that can be added to the Rebate Calculation Supplemental Form to effectively accomplish the reconciliation.

We look forward to discussion of these points along with the comments of other parties as we work to finalize this important regulation.

Very truly yours,

A large, stylized handwritten signature in black ink, appearing to read 'Louis S. Felice', is written over the typed name and title below it.

Louis S. Felice

Assistant Deputy Superintendent and Bureau Chief
Health Bureau



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

By electronic mail

October 11, 2010

Honorable Sandy Praeger
Chair, NAIC Health Insurance and Managed Care (B) Committee

1310 G Street, N.W.
Washington, D.C. 20005
202.626.4780
Fax 202.626.4833

**Re: NAIC Model Regulation for Uniform Definitions and Standardized Rebate
Calculation Methodology for Plan years 2011, 2012 and 2013 Per Section 2718(b) of the
Public Health Service Act**

Dear Commissioner Praeger:

The Blue Cross Blue Shield Association (BCBSA), which is comprised of the 39 independent Blue Cross and Blue Shield Plans (“Plans”) that provide health coverage to nearly 100 million Americans, appreciates the opportunity to provide comments as the National Association of Insurance Commissioners (NAIC) finalizes its work on recommendations to the Department of Health and Human Services (HHS) on Section 2718 of the Public Health Service Act (PHSA), dealing with the rebate reporting component of the medical loss ratio (MLR) requirement.

The NAIC’s PPACA Actuarial Subgroup should be commended for the extensive amount of valuable time and effort that has been put forth in crafting the Issue Resolution Documents (IRDs) and the proposed Model Regulation. We very much appreciate the opportunity we and other interested parties have had to participate in the process, and we believe this open process has led to a good work product. We do have a few remaining concerns for the consideration of the Health Insurance and Managed Care (B) Committee, as well as a few minor technical fixes.

We appreciate the B Committee taking these additional points into consideration as you finalize the proposed model regulation.

Comments

1. Section 3.B(16) “Minimum Medical Loss Ratio” – add Drafting Note

Any exception to the MLR requirement in a state market should apply to all health insurance issuers in that state market.

IRD041 addresses the issue of whether MLR exceptions should be considered. Recognizing there may be situations that justify some type of exception for the market, the IRD suggests HHS coordinate with the state insurance commissioner to prevent market disruption. All discussion on this issue to date has focused on whether the MLR would negatively impact a specific market (i.e., individual, small or large group), not specific issuers in the market. See the following description from IRD041:

The Secretary might, for example, after reviewing the characteristics of a state's individual market with the state insurance commissioner, adjust the rebate calculations in the individual market to be based on 65% for 2011 for a state that currently has a minimum loss ratio of 55%, actual loss ratios for some issuers that are between 55% and 70%, and only four issuers in the state currently offering policies to new enrollees.

As referenced in IRD041, Section 2718 (b) (1) (A) (ii) allows the Secretary to adjust the MLR percentage "with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such state"[emphasis added].

Throughout the discussion on a number of IRDs, regulators stressed the importance of a "level playing field" approach regarding market rules. Also, several of the IRDs considered the issues of credibility with smaller plans, and the regulation incorporates a credibility table and adjustments that were fully vetted to address this issue.

For these reasons, we suggest that a Drafting Note be added following the definition of "Minimum medical loss ratio standard" in the model regulation to address the "exception" situation:

Section 2718 (b) (1) (A) (ii) allows the Secretary to adjust the MLR percentage "with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such state. States seeking an exception should consider factors and characteristics that impact the market (consider the IRD041 listing). Any exception to the MLR requirement granted to a state for a particular market segment should apply to all issuers doing business in that market segment in the state.

2. Appendix C. Excerpts for the Supplemental Health Care Exhibit Instructions

Line 1.6 – State Insurance, Premium and Other Taxes and Assessments - Clarify scope to include state-required cost transfers.

At least one member Blue Plan is required by state law to cross subsidize a line of business with other lines. We are concerned this type of state-required cost transfer might not fit under the language in Appendix C, Line 1.6. Consequently, we recommend the following clarification to address this situation but not otherwise change the intent or scope of this provision:

Line 1.6 – State Insurance, Premium and Other Taxes and Assessments

Include: Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly, premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the state, or cost transfers authorized by state law.

3. Section 6. Frequency and Timing of Medical Loss Ratio Rebate Calculations and Rebate Payments

Identify rebate payment recipients as policyholders rather than enrollees.

We recommend the NAIC clarify who receives the rebate in this model regulation. The PPACA Actuarial Subgroup addressed this issue in IRD019, recommending that payment of rebates should be made to the policyholder and not enrollees. However, IRD019 was withdrawn before final resolution, as we understand, on the basis that this payment issue was beyond the scope of the NAIC's authority under the ACA.

Distributing the rebate to enrollees would result in the distribution of rebates to employees who may make little or no contribution toward their premium (35% of small employers pay the entire employee premium for single coverage according to the 2010 Kaiser Family Foundation Employer Health Benefits 2010 Annual Survey). In addition, rebate payments to enrollees could result in payments to dependents, including minor children.

We recommend that the B Committee consider whether the NAIC can provide guidance on this issue, and if so, to include a provision in Section 6 to provide that rebate payments be directed to the policyholder.

The following represent our request for additional consideration on a few remaining technical points:

1. Section 10. Medical Loss Ratio Rebate Calculation for Plan Year 2013

Rebates should be subtracted from future year calculations if the experience is used in the calculation.

Calculations for 2013, which include the experience from 2011 and 2012, should be made net of any rebates paid in those years. This would be consistent with the evaluation from IRD006 as follows:

“The law specifies the level of MLR that will dictate a rebate. The excess premium is to be returned to the policyholder as a rebate. If a company were to be subject to “double jeopardy” by not considering previous refunds, the result would be nonsensical . . .”

2. Section 3.B.(16) – Minimum Medical Loss Ratio Standard

Clarify that MLR Rebate Standards are Thresholds.

We suggest the following changes to Section 3.B.(16) to better convey that the MLR rebate requirements are thresholds and not “targets.” Clarifying this term also would make an important distinction and avoid confusion between these MLR provisions and true minimum loss ratio standards that may exist in state law:

“~~Minimum~~ Medical loss ratio threshold standard” means the percentage determined in accordance with Section 2718 (b) (1) (A) (i) or (ii) of the PHSA. In the case of ~~minimum~~ medical loss ratio ~~standards~~ thresholds that are not constant over an averaging period, the threshold-~~minimum standard~~ will be the average of the ~~standards~~ thresholds used in each year weighted by earned premium less Federal and State taxes and licensing or regulatory fees.

Thank you again for the opportunity to comment, and we look forward to continuing to work with you on this issue.

Sincerely,

/signed/

Joan Gardner
Executive Director, State Services

cc: Members, Health Insurance and Managed Care (B) Committee
Steve Ostund, Chair, NAIC PPACA Actuarial Subgroup
Lou Felice, Chair, Health Reform Solvency Impact (E) Subgroup
Brian Webb, NAIC Staff
John Engelhardt, NAIC Staff
Eric King, NAIC Staff
Todd Sells, NAIC Staff
Shari Westerfield, BCBSA



AMERICAN ACADEMY *of* ACTUARIES

Oct. 8, 2010

Commissioner Sandy Praeger
Chairperson, Health Insurance and Managed Care (B) Committee
National Association of Insurance Commissioners

**Re: Regulation for Uniform Definitions and Standardized Rebate Calculation
Methodology for Plan Years 2011, 2012, and 2013 per Section 2718(b) of the Public
Health Service Act**

Dear Commissioner Praeger:

The American Academy of Actuaries’[†] Medical Loss Ratio Regulation Work Group appreciates this opportunity to provide input to the Health Insurance and Managed Care (B) Committee of the National Association of Insurance Commissioners (NAIC B Committee) regarding its Oct. 4, 2010, exposure draft of the above-named regulation (MLR rebate regulation).

We acknowledge and appreciate the sense of purpose with which the NAIC has undertaken its charge, as defined earlier this year with the adoption of Section 2718(c) of the Public Health Service Act, to provide the Department of Health and Human Services (HHS) with swift input relevant to the development of regulations implementing Section 2718 loss ratio reporting and rebate requirements. As actuaries, we are particularly pleased that the NAIC tasked a group of regulatory actuaries, the PPACA Actuarial Subgroup (actuarial subgroup), with primary responsibility for development of the MLR rebate regulation, which we believe is a critical regulatory issue. Consistent with the Academy’s mission, our work group throughout these past five months has sought to provide the actuarial subgroup and other stakeholders with input regarding this subject, and we are pleased that many of the actuarial subgroup’s technical Issues Resolution Documents contain reference to letters written by the Academy’s MLR Work Group. We hope our input has been helpful throughout this technical phase.

Now that the NAIC B Committee has exposed for comment the actuarial subgroup’s draft MLR rebate regulation, however, we believe it is important to take stock of the regulation as a whole. In this letter, our goal is to provide the NAIC B Committee and other stakeholders with our perspectives on the MLR rebate regulation—viewed as much from a public policy standpoint as from a purely technical standpoint. We have attempted to strike a balance between brevity and completeness by including a number of endnotes that refer to places in other documents in which the issues mentioned in this letter previously have been more fully articulated.

[†] The American Academy of Actuaries (“Academy”) is a 17,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

Guiding Criteria

To start, it is important to state what we see as the relevant guiding criteria for assessing the MLR rebate regulation:

1. *Appropriate construction of the Section 2718 medical loss ratio (rebate MLR) is critical; thresholds for rebate payment always can be recalibrated to achieve public policy objectives, but uncompensated biases in the underlying metric may adversely affect the functioning of insurance markets and thereby may adversely affect consumers.* The decision of whether to include a particular item in the rebate MLR should be based on whether the inclusion of that item produces a more meaningful metric, consistent with other criteria discussed below. With a well-constructed rebate MLR metric, the thresholds (e.g., 80 percent or 85 percent) at which rebate payment are required always can be recalibrated by regulators, if necessary, to achieve desired public policy objectives. But if the design of the rebate MLR metric systematically favors certain types of companies over others, the consequences on competition in insurance markets may be indelible and unwanted, possibly to the detriment of consumers' collective interests.
2. *The rebate MLR should be designed to be as comparable as possible across different types of health insurance issuers.* Many differences exist among health insurance issuers, and those differences manifest themselves via predictable differences in the traditional medical loss ratio (incurred claims divided by earned premium).¹ In an environment in which different types of issuers (e.g., staff model HMOs, group practice HMOs, PPOs, etc.) now find themselves subject to a common measuring stick, care should be taken to define that metric in a way that promotes a level competitive playing field, without rewarding certain types of health insurers and disadvantaging others.
3. *Recognizing that the definition of the rebate MLR will affect future insurer behavior, the rebate MLR should be designed in a manner that promotes, rather than discourages, insurer behavior that is consistent with the underlying aims of the Affordable Care Act.* The MLR rebate regulation can be viewed as an incentive mechanism, discouraging insurers from making expenditures that do not act to increase the insurer's rebate MLR. To that end, the design of the rebate MLR should encourage insurer behavior that would meet the ACA goal of addressing the cost of health care coverage.
4. *The determination of rebates to consumers should be structured in an equitable manner that reasonably reflects how insurers manage and price risks and how insurance is purchased.* The introduction of rebate requirements creates an asymmetry in the insurer's risk profile—upside risk is now returned to consumers while downside risk continues to be borne by the insurer. In this context, requiring rebates to be calculated at a more granular level than the level at which the insurer manages risk would impair the functioning of insurance markets. For example, the one extreme of requiring rebates to be calculated at the policyholder level would be impractical since, in any given year, a small percentage of policyholders generate a large percentage of overall claims. More subtle issues regarding the granularity of rebate calculations arise from situations in which a customer has contracts with multiple related legal entities but where those contracts are

underwritten and priced in an aggregate manner, or situations in which an entity uses multi-state experience for pricing purposes.

5. *The introduction of rebate requirements should be done in a manner that does not impede competition in insurance markets.* In particular, suitable transition mechanisms may be needed in the individual market, in which historical pricing practices have been oriented around lifetime rather than annual loss ratio targets, and in which relatively low medical costs combined with relatively equal administrative costs naturally lead to lower loss ratios.²

Positive Aspects of the Regulation

Many stakeholders have noted that the statutory language of Section 2718 contains a number of ambiguities and internal inconsistencies, which heighten the importance of regulatory interpretation to create a sound basis for implementing the underlying intent of this particular aspect of the Affordable Care Act. In that context, we wish to express our support for a number of interpretive decisions made by the actuarial subgroup during the development of the MLR rebate regulation that, in our view, result in a more sound regulatory framework relative to other potential decisions that could have been made.

Key examples of the positive aspects of the draft regulation include the following:

- *Calendar Year Orientation.* The statute's use of the phrase "plan year" in connection with rebate determination is somewhat confusing. By deeming, within the MLR rebate regulation, that "plan year" simply means "calendar year," the actuarial subgroup has taken a highly practical position, creating consistency with existing insurance regulatory financial reporting practices.³
- *Granularity of Rebate Determination.* The MLR rebate regulation's overall framework is that business is to be grouped together by legal entity, state of policy issuance, and market (individual vs. small group vs. large group) for purposes of determining rebates. Appropriate modifications to this framework have been made to cover specific situations in which risk is legally borne by different legal entities but is priced & managed in a more aggregated fashion (e.g., the "dual option with blended rates" case). The selected regulatory framework is one of several reasonable potential approaches. Given that the actuarial subgroup's selected approach carries with it additional complexities that will create difficulties for both companies and for regulatory auditors, alternate approaches involving greater aggregation may be equally reasonable.
- *Existence of Credibility Adjustments.* All else being equal, a smaller block of business will experience greater fluctuation in actual loss ratios, both above and below target, than a larger block, due simply to statistical fluctuation. This phenomenon has solvency implications in a framework in which rebates to consumers are required when loss ratios are below target, whereas contributions to surplus are reduced when loss ratios are above target. The application of credibility adjustments varying with block size, as done in the MLR rebate regulation and following the long-established precedent of the Medicare

Supplement rebate formula, helps to create a more level playing field between smaller blocks of business and larger blocks, thereby protecting companies' surplus positions and promoting competition in insurance markets.⁴

- *Existence of Denominator Adjustments for Taxes and Fees.* Some health insurance issuers are subject to federal income taxes while others are not. Levels of premium taxes and state regulatory assessments can vary significantly across types of issuers, states, and insurance markets. To be able to make fair comparisons across the entire industry, without putting certain companies at a disadvantage for regulatory factors that may not be within their control, the rebate MLR needs to be designed in a manner that makes adjustments to reflect all of these types of taxes and fees.⁵ We are pleased that the plain language of the statute supports making such adjustments, and that the NAIC has interpreted that statutory language in a relatively broad manner—despite suggestions from some legislators that a narrower interpretation is appropriate.
- *Existence of Numerator Adjustment for Change in Contract Reserves.* Existing pricing practices in the individual market are such that loss ratios may increase materially with the length of time for which the policyholder has maintained insurance coverage. As a result, the overall claims-to-premiums ratio for a block of individual business may be materially influenced by the “duration” of that block—that is, by the mix within the block between recently issued policies and older policies.⁶ Allowing the change in contract reserves to be included in the rebate MLR numerator can help normalize the rebate MLR across different health insurance issuers having individual blocks of varying durations. We believe the statute would allow this adjustment, and the actuarial subgroup has recognized the value of making an adjustment of this type. As discussed later in this letter, however, further technical refinements in this area may be warranted. This may become much more important to the extent that some carriers exit the individual market and the carriers remaining in the market experience a disproportionate mix of new business.
- *Use of a Runout Period for Measuring Incurred Claims.* Financial reports prepared at the end of a calendar year necessarily include estimates of the health insurance issuer's liability for claims incurred but not yet paid. Subsequent variance between actual claim payments and the original liability estimate can distort the loss ratios reported for adjacent calendar years.⁷ Restating the incurred claims for the calendar year using three months' of claims runout, as proposed by Section 6B of the MLR rebate regulation, is an appropriate enhancement to the accuracy of the rebate calculation.

Areas Meriting Further Consideration

While as noted above there are many areas in which we believe the decisions made during the development of the MLR rebate regulation were well-reasoned, there also are several areas in which we would encourage the NAIC B Committee to reconsider the regulatory direction chosen by the actuarial subgroup.

Key areas where we believe further consideration is necessary include the following:

- *Magnitude of Credibility Adjustments.* As noted earlier, we support the inclusion of credibility adjustments, which address the impact of statistical fluctuation on smaller blocks of business. We are somewhat concerned that the magnitude of credibility adjustments selected by the actuarial subgroup may not be sufficiently large enough to mitigate the risks faced by smaller blocks of business in an environment in which upside risk is returned to consumers via rebates. In an earlier letter to the actuarial subgroup, we compared the potential impact of applying 50th percentile adjustments (like those adopted by the actuarial subgroup) against alternatives, such as 80th percentile and 90th percentile adjustments.⁸ As illustrated in that letter, using 50th percentile adjustments rather than 80th percentile adjustments, particularly for a block of business having fewer than 10,000 life-years, may materially reduce the insurer's expected contribution to surplus from the block. Increasing the magnitude of the credibility adjustments may help keep insurance markets attractive to smaller competitors, which would enhance consumer choice.
- *Cost Containment Expenses (CCE) / Loss Adjustment Expenses (LAE).* Prior to the drafting of the Affordable Care Act, the Academy's Health Practice Council recommended that any new federal loss ratio requirements should be defined in such a way that insurers' cost containment expenses, as defined under statutory accounting (SSAP 85), are included in the numerator.⁹ Since then, we have continued to argue that including all CCE within the numerator of the rebate MLR, as opposed to only including those CCE that meet a more stringent definition in the MLR rebate regulation of "expenses to improve health care quality," would create a better metric and would facilitate comparisons in loss ratios across different entities.¹⁰ We also have noted that the absence of CCE from the rebate MLR creates what economists refer to as a "perverse incentive" with respect to measures insurers take to promote affordability of coverage; this seems misaligned with the underlying affordability objectives of Section 2718.¹¹

In addition, including all LAE in the rebate MLR has some appeal, in that the resulting metric would better reflect differences in business models across issuers and also would reflect the value that consumers receive from the insurer's benefit-processing activities for healthcare services that do not generate claims in light of policyholder cost-sharing features.¹² Support for this approach is provided by the explicit reference to "loss adjustment expenses" within the statutory language of Section 2718(a); however, the actuarial subgroup has given little weight in its deliberations to the use of this phrase in the statute.¹³ Given the explicit legislative reference to LAE, further regulatory consideration of this issue seems warranted.¹⁴

- *Reinsurance.* The MLR rebate regulation has been drafted in a manner that excludes the impact of most reinsurance arrangements from the calculation. We sympathize with concerns expressed by the actuarial subgroup during its calls that unconstrained credit for reinsurance within the rebate MLR could allow health insurance issuers too much latitude to use reinsurance as a vehicle for manipulating the results of the calculation. We nevertheless believe that the regulation's incorporation of reinsurance should be expanded somewhat, specifically with respect to allowing issuers to reflect excess risk

reinsurance treaties, which frequently are an important risk management tool for smaller companies.¹⁵

- *Methodologies for Contract Reserves.* As noted earlier, we support the inclusion in the rebate MLR of a change-in-contract-reserves component. But in light of technical nuances in existing statutory accounting guidance, together with an apparent diversity of accounting practice, we previously recommended to the actuarial subgroup that the contract reserves used in the rebate MLR calculation should be uncoupled from the contract reserves reported in the statutory financial statements.¹⁶ (Precedent for a federally defined contract reserve methodology, differing from statutory accounting, already exists within federal health insurance regulation.¹⁷) We continue to believe that greater guidance needs to be specified within the MLR rebate regulation regarding the methodologies and assumptions that may be used to determine contract reserves for rebate MLR calculation purposes, with clarification that those methodologies and assumptions legitimately may differ from those used to calculate the statutory-basis contract reserves (or to justify holding zero statutory-basis contract reserves).
- *Runout Period for Measuring Earned Premium.* As noted above, we support the MLR rebate regulation's use of a three-month runout period for measuring incurred claims. We believe that, for consistency, it is important to also use a three-month runout period for measuring earned premium. Without this, in some cases, significant inconsistencies could arise between the numerator and denominator (e.g., due to retroactive membership adjustments), which could materially distort the rebate calculation.
- *Treatment of 2011/2012 Rebates in 2013 Calculation.* Any mechanism that requires "rebates to be paid on rebates" does not seem consistent with the intent of the Affordable Care Act. Section 10 of the MLR rebate regulation, however, contains such a mechanism—when using cumulative 2011-2013 experience to determine the rebate payable on 2013 premiums, no adjustment to that experience is made for any rebates previously paid on 2011 or 2012 premiums.¹⁸ To the extent that companies have already returned "excess" premium to consumers in the form of rebates, we believe the companies have met their obligations under the law. Disallowing these previous rebate payments in determining the need for rebates in future years could be requiring return of premium in excess of the amounts required under Section 2718.
- *Differences in Plan Benefit Designs.* It is important to appreciate that policy and benefit administration expenses (as opposed to distribution/marketing expenses) as a general rule do not differ materially based on the actuarial value (AV) of the benefits provided.¹⁹ As a result, loss ratios for such policies as HSA-eligible high-deductible health plans naturally will be much lower than loss ratios for more expensive policies having more generous benefit designs. Holding all carriers within a market to a common loss ratio threshold, therefore, will put at a disadvantage carriers whose mix of business is more heavily weighted towards lower-AV products. The NAIC B Committee may wish to consider whether this situation can and should be addressed via regulation. For example, it may be viable to develop a "product mix adjustment factor," analogous to the credibility

adjustment factor found in the MLR rebate regulation in that it would be added to (or subtracted from) the actual MLR before comparing to the relevant rebate threshold.²⁰

Areas Not Adequately Addressed

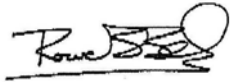
There are a number of aspects of rebate calculation and administration that are not addressed in the MLR rebate regulation, even though they may have been discussed at various times by the actuarial subgroup. The scope of the MLR rebate regulation as exposed presumably is intended to align with the scope of the NAIC's statutory charge to provide input to HHS under Section 2718(c).

Areas in which further elucidation, by the NAIC and/or by HHS, will be important include:

- *Transition Guidance, Particularly for the Individual Market.* We previously have highlighted the need for regulators to consider adopting transitional guidance on the application of Section 2718 to the individual market, and to announce expeditiously that guidance in order to have a timely influence on carrier decision-making processes.²¹
- *Identity of Rebate Recipients.* Read literally, the Section 2718 requirement to make rebate payments to “enrollees” often may be inequitable, to the extent that premiums were paid in full or in part by the policyholder (e.g., an employer benefit plan) rather than by the enrollees.²² Payment of rebates by the insurer to the policyholder would be a fair and appropriate interpretation of the statutory requirement.
- *Clarity on Definitions.* We have observed considerable confusion in understanding precisely what “small employer” means for purposes of Section 2718 in 2011-2013, and to a lesser extent in understanding which types of health insurance products are within the scope of Section 2718 requirements. While we recognize that these fundamentally are issues of statutory construction and interpretation, we nonetheless encourage regulators to clarify these issues as much as possible within regulation.
- *Reporting by Issuers.* Section 2718(a) creates a requirement for health insurance issuers to report on loss and expense ratios to HHS, and ultimately to the public. Over the past few months, the NAIC has developed two different new reporting mechanisms: the Supplemental Health Care Exhibit adopted in August and, most recently, the Rebate Calculation Form included in the MLR rebate regulation. There may be some confusion as to whether either, or both, of these mechanisms is intended to satisfy the Section 2718(a) requirement, or whether a third new reporting mechanism is still to be developed. The proliferation of multiple reporting mechanisms brings with it risks of creating confusion among consumers as to expectations about rebates, as well as risks of inconsistent treatment in the translation of data between reporting formats.

Thank you again for this opportunity to comment. If we can be of further assistance, please contact the Academy's senior federal health policy analyst, Heather Jerbi, at jerbi@actuary.org or 202-223-8196.

Sincerely yours,



Rowen B. Bell
Chairperson, Medical Loss Ratio Regulation Work Group
American Academy of Actuaries

Cc: Steven Larsen (Deputy Director, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services)

¹ For a discussion of ways in which the classical claims-over-premiums loss ratio varies systematically based on characteristics of the health insurance issuer, please see Pages 4-7 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

² For discussions of historical pricing practices in the individual market and the short-term implications with respect to MLR-based rebate requirements, please see Pages 10-15 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf), and also Pages 3-8 of the MLR Work Group's June 7, 2010, letter to the actuarial subgroup (http://www.actuary.org/pdf/health/AAA_Contract_Reserves_060710_final.pdf).

³ For a more complete discussion of this issue, please see Pages 42-43 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

⁴ For further discussion, please see the MLR Work Group's letters to the actuarial subgroup dated May 12, 2010 (http://www.actuary.org/pdf/health/aaa_statistical_credibility_to_naic_051210_final.pdf) and May 20, 2010 (http://www.actuary.org/pdf/health/aaa_statistical_credibility_response_100520_final.pdf).

⁵ For related comments, please see Pages 6-7, and also Pages 25-26, of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

⁶ For further discussion, please see Pages 3-8 of the MLR Work Group's June 7, 2010, letter to the actuarial subgroup (http://www.actuary.org/pdf/health/AAA_Contract_Reserves_060710_final.pdf).

⁷ For an illustrative example, please see Pages 8-9 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

⁸ The table on Page 3 of the MLR Work Group's May 20, 2010, letter to the actuarial subgroup (http://www.actuary.org/pdf/health/aaa_statistical_credibility_response_100520_final.pdf) illustrates the expected impact of different credibility adjustment levels on the insurer's net-of-rebate loss ratio. That table suggests that using a 50th percentile adjustment, rather than (for example) an 80th percentile adjustment, could disadvantage smaller carriers.

⁹ See Page 3 of the Academy's *Critical Issues in Health Reform: Minimum Loss Ratios* issue brief (http://www.actuary.org/pdf/health/loss_feb10.pdf), originally issued in mid-2009 and reissued in early 2010.

¹⁰ For further discussion, see Pages 1-3, and also Pages 8-11, of the MLR Work Group's May 17, 2010, letter (http://www.actuary.org/pdf/health/aaa_mlr_naic_letter_on_exhibit_051710_final.pdf) to the NAIC Health Care Reform Solvency Impact Workgroup.

¹¹ See Pages 12-13 of the MLR Work Group's May 17, 2010, letter to the NAIC Health Care Reform Solvency Impact Workgroup (http://www.actuary.org/pdf/health/aaa_mlr_naic_letter_on_exhibit_051710_final.pdf) for an illustrative example.

¹² See Pages 10-11 of the MLR Work Group's May 17, 2010, letter to the NAIC Health Care Reform Solvency Impact Workgroup (http://www.actuary.org/pdf/health/aaa_mlr_naic_letter_on_exhibit_051710_final.pdf) for further discussion.

¹³ For example, consider the following passage from Page 4 of the NAIC's May 12, 2010, response to HHS, which originally was drafted by the actuarial subgroup: "It is unclear whether these are the types of expenses intended by the term 'loss adjustment expense' in PPACA, or whether the parenthetical indicates that in this context 'loss adjustment expense' is intended to mean the change in contract reserves."

¹⁴ For a more complete discussion of different ways of reading Section 2718(a), please see Pages 20-25 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

¹⁵ For further discussion of reinsurance issues, please see Pages 31-32 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

¹⁶ See Pages 8-12 of the MLR Work Group's June 7, 2010, letter to the actuarial subgroup (http://www.actuary.org/pdf/health/AAA_Contract_Reserves_060710_final.pdf).

¹⁷ CFR Title 42 §403.253(b)(2)(ii) defines a contract reserve methodology to be used for federal Medicare Supplement loss ratio certifications.

¹⁸ Note that the situation for 2013 is unique, relative to situations that would exist for later years. For example, a carrier's 2013 experience would, due to the statutory use of three-year averaging, partially influence the determination of rebates for each of 2013, 2014, and 2015. By contrast, a carrier's 2011 experience will partially influence the determination of rebates for 2013, even though that same 2011 experience already had total influence over the determination of rebates for 2011. This places outsized emphasis on 2011, the remedy for which is to allow rebates paid on 2011 experience to be incorporated in the 2013 calculation.

¹⁹ For further discussion of this issue, please see Page 4 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

²⁰ It is true that the credibility adjustment factor in the MLR Rebate Regulation includes a component that varies based on deductible. That component, however, is relevant only for partially credible blocks of business. For a fully credible block, no adjustment is made to the rebate MLR to account for mix of business by deductible. In addition, the deductible component within the credibility adjustment factor is intended to account only for increased statistical fluctuation with higher-deductible products. It does not account for the fact that higher-deductible products normally will exhibit higher ratios of administration expenses to premiums.

²¹ Please see the MLR Work Group's April 28, 2010, letter addressed to two NAIC working groups (http://www.actuary.org/pdf/health/letter_academy_mlr_individual_market.pdf), as well as Pages 10-15 of our May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

²² See a related discussion on Page 44 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).



11 October 2010

Honorable Sandy Praeger, Chair
NAIC Health Insurance and Managed Care (B) Committee
c/- Kansas Department of Insurance
420 S.W. 9th Street
Topeka, Kansas 66612-1678

VIA E-MAIL

Dear Commissioner Praeger:

We write today on behalf of America's Health Insurance Plans (AHIP), the nation's trade association representing nearly 1,300 member companies providing health, long-term care, dental, disability and supplemental coverage to more than 200 million Americans. We appreciate the opportunity to provide comments on the recently exposed *Regulation for Uniform Definitions and Standardized Rebate Calculation Methodology for Plans Years 2011, 2012 and 2013 Per Section 2718(b) of the Public Health Service Act*.

The time frame for commenting on this regulation, which was only exposed for the first time one week ago, precludes our providing more comprehensive and detailed comments than we have here. Given this abbreviated comment period, AHIP provides the following comments to illustrate why the Health and Managed Care (B) Committee should not adopt this regulation in its current form. We note several instances where regulatory language is not well defined, where the meaning of the language differs in a technical, legal sense from what we understand to be the intent of the document and where issues such as those noted below are not sufficiently addressed. Because of the abbreviated comment period, the following are not intended to be comprehensive; we urge the Committee to take the time necessary to revise this document prior to adopting it, and to ensure that all comments and suggestions, whether technical or substantive, are fully and completely discussed and that the medical loss ratio calculation is correct and accurate.

GENERAL COMMENTS

As an overarching general comment, we urge the NAIC to be clear and accurate when it describes in regulatory language the "purpose" or the "scope" of the draft. As this regulation is either adopted by states or included in federal regulatory language, it will be subject to discussion and interpretation by many who have not been involved in the conference calls that preceded the exposure of the regulation. The language used in the regulation is the first area that administrators and courts will use to determine its true intent, and therefore how its language should be interpreted. Where the words in the regulation are can have more than one meaning,

then these areas of purpose and scope can become quite important. We therefore make the following general comments.

The title of the regulation is the “Affordable Care Act Medical Loss Ratio Rebate Regulation.” But the stated purpose of the project that the NAIC has undertaken is in response to the charge set out in Section 2718 of the Public Health Service Act. That charge reads as follows: the NAIC “shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities...” (*emphasis supplied*)

The goal of the regulation is not to create rebates; the regulation is not accurately described as the “rebate regulation” but rather should be the “Medical Loss Ratio Regulation.” Similarly, in the “Purpose” paragraph, the purpose of the regulation is not to calculate the “method for rebates of health insurance premiums” but to calculate the manner in which the medical loss ratio (MLR) is to be derived. The rebate is not the focus of the medical loss ratio, nor was it the focus of the federal legislation. As a number of PPACA Actuarial subgroup members noted over the many discussions on this topic, the purpose of the rebate calculation is not to guaranty a rebate payment, but is to measure carriers’ achievement of the statutory loss ratio requirements. Carriers who miss this mark must pay rebates, which are an incentive to reach the loss ratio goal. We therefore suggest revising the purpose to ensure that the regulation is in synch with the statutory purpose and requirements, as follows:

The purpose and intent of this Regulation are to promulgate uniform definitions and a standardize methodology for calculating the medical loss ratio as described in Section 2718 of the Public Health Service Act.

This issue arises also in the substantive provisions of the regulation. Section 5.A. states that “Rebates shall be calculated at the licensed entity level...” In fact it is the medical loss ratio that is calculated, not the rebate. The draft seems to be written with the expectation that all plans will miss the MLR mark. We believe that is an unsubstantiated conclusion; the regulatory language should not lead a future reader to conclude that a rebate is expected, anticipated or required. The sentence should be “Medical loss ratios shall be calculated...”

Similarly, the language in the Section 6 of the draft regulation should be changed to remain true to the legislation intent and purpose. Section 6.A. states that “Rebates shall be calculated annually...” Actually what is being calculated is the MLR, and so the language should read “Medical loss ratios shall be calculated annually...” We make the same comment and offer the same solution for the language in subsections B and C of Section 6.

In a number of places throughout the draft, the language references the new NAIC Supplemental Health Care Exhibit (“the supplement”). This is appropriate, but there should be a recognition that over time the supplement, and its definitions, will evolve. Indeed, we are aware that the NAIC Executive and Plenary have not finalized the supplement’s quality definitions, and certain other areas in the definitions are still under discussion. In fact the Health Reform Solvency Impact Subgroup on October 7 released a list of changes it intends to make to the supplement. By referencing a specific version of the supplement, the regulation precludes any flexibility for the states that adopt this model to incorporate necessary changes. Future changes to the

supplement would require specifically amending the state's regulation; the same is true for any regulation or bulletin provided by the federal regulatory agencies. We suggest this is unnecessarily cumbersome, and inappropriate given the fact that the recommendations have already been made to change the August 17 document version of the supplement. The regulation, if adopted as drafted, will ultimately be out of alignment with the supplement; an unintended consequence of this lack of alignment will be to hinder the intent of the NAIC to incorporate the appropriate elements into the MLR calculation. This problem may be remedied by including the phrase "and any amendments thereto" immediately after the date. We further suggest that appropriate regulatory drafting requires the date be spelled out as "August 17, 2010" rather than numerically represented as 8/17/10.

SPECIFIC COMMENTS

SECTION 3. DEFINITIONS

As an initial overarching comment, we are concerned that there continue to be many terms, as illustrated below, that need either a definition or a cross-reference to existing NAIC models, manuals or handbooks, or to state law. The model is inconsistent in its assumptions whether technical terms should, or should not, be referenced back to existing source material. This will cause significant interpretive problems as this regulation is implemented over the next three years. We urge the Committee to include definitions where necessary and cross-references to already defined terms so as not to encourage state courts or regulatory authorities to re-define technical accounting terms that have widely recognized meanings either in the supplement, in the NAIC's Accounting Practices and Procedures Manual, or the Annual Statement instructions.

A. (2) Earned premium

As a preliminary matter, we note that within this definition the following terms are either undefined or lack an appropriate cross reference:

"Entity," "One entity," or "another entity" need to be defined to ensure the appropriate reference to either to health carriers or health insurance issuers, as appropriate, and not to lead the reader to assume that self-funded employer groups or other corporations, partnerships, employers, associations or other entities are intended to be included.

The definition of earned premium is inconsistent with the definition of incurred claims. As written, for example, earned premiums for 2011 will reflect changes between the 12/31/2010 estimate of premiums due and the actual premiums paid in 2011 for coverage during 2010. It will not reflect similar differences as of year-end 2011. This same approach has been rejected for incurred claims. They will not reflect adjustments to year-end 2010 estimates but will adjust year-end 2011 values for changes that become known during the first quarter of 2012. We recommend changes to the instructions in Appendix A that will make the adjustments consistent for both earned premiums and claims in order to consistently address occurrences during the first quarter of the following year. With this change, the elimination of adjustments for year-end 2010 should be excluded within this definition.

A. (3) Expenses to improve health care quality

Please see our comments to A. (1), above.

A. (6) Individual health plan

Please see our comment to A. (1), above. This definition should be identical to that used in the supplement, and so should be defined thus:

“Individual Health Plan” means health insurance where the policy is issued to an individual covering the individual and/or their dependents in the individual market. This includes conversions from group policies, but does not include policies reported in other than Column 1 of the Supplemental Health Care Exhibit.

B. We continue to question the rationale for drafting two sections devoted solely to definitions and suggest they be merged. Creating two definitional sections is confusing and may lead readers to the inappropriate conclusion, based on long-standing rules of statutory construction, that these definitions are somehow different in their scope or applicability than the definitions in Subsection A. The fact that some definitions are required to be included in this regulation by the Affordable Care Act, and some are included because the regulation’s complexity requires them is immaterial as a legal matter. The subsections should be merged.

B. (1) ACA

The definition should have a full and complete citation to the Affordable Care Act.

B. (3) Business sold through an association

The definition of association business should specifically reference the reporting entity’s state law definition of association business.

B. (8) Direct paid claims

“Direct paid claims” is used only in the definition of ‘incurred claims’ but is not as complete as the definition of claims in the Supplement. It should specifically state that it includes claims that meet the definition of Direct Claims Incurred as presented for Line 2 of Part 2 of the supplement instructions. While an adjustment for fraud reduction efforts is included (and we assume would be based on the definition in the supplement but this is not clear), the following items are included in “incurred claims” for purposes of the supplement, but do not appear in the definition. We recommend that they be specifically included:

Line 2.4 -- State Stop Loss, Market stabilization and claim/census based assessments
Any market stabilization payments or receipts by insurers that are directly
tied to claims incurred and other claims based or census based
assessments.

State subsidies based on a stop-loss payment methodology.
Unsubsidized state programs designed to address distribution of health risks across health insurers via charges to low risk carriers that are distributed to high risk carriers. Refer to SSAP 35 (Guaranty Fund and Other Assessments).

B. (13) Group conversion charges

“Group conversion charges” should allow for the charge to be either a ‘portion of the earned premium’ or a separate charge since either, if reported in the statement, should be transferred in accordance with the last part of the definition of incurred claims in Section 3.A.(5).

B. (14) Incurred medical pool incentives and bonuses

Please see our comments to A. (1), above. This definition should be identical to the one used in the supplement.

B. (17) Net healthcare receivables

Please see our comment to A. (1), above.

B. (25) Unearned premium reserves

“Unearned premium reserves” is no longer used in the regulation and therefore can, and should, be deleted.

SECTION 4. APPLICABILITY AND SCOPE

We are concerned that the scope section remains overly broad. Section 2718 only requires carriers in the large group, small group and individual markets to meet target loss ratios. Carriers writing exclusively excepted benefits, therefore, should not be subject to the reporting requirements in 2718 (a) or (b). For clarity we suggest that the scope of the regulation be limited specifically to “... any health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) through health plans as defined in Section 3.A.(4), as provided for in Section 2718 of the PHSA for plan years 2011, 2012 and 2013.”

SECTION 5. LEVELS OF AGGREGATION FOR MEDICAL LOSS RATIO REBATE CALCULATIONS

The use of the word “experience” in subsection C appears to be intended to have the same meaning as “experience” in Sections 8.B., 9.B. and 10.B. However, the language in Subsections 8.B., 9.B and 10.B, by their plain words, are limited only to apply to that paragraph, and so cannot be interpreted as having the same meaning in Section 5. We recommend that an appropriate definition be added to this subsection as well.

SECTION 6. FREQUENCY AND TIMING OF MEDICAL LOSS RATIO REBATE CALCULATIONS AND REBATE PAYMENTS

Subsections A, B and C, as well as the remainder of the regulation relate to the “total rebate amount” as that term is used in 2718(b) (1) (B) and not “actual rebates.” Actual rebates refers to the pro-rata payment or premium credit; that is, the amounts in subsection D. Care should be taken that the two are not confused. In addition, we note that Subsection B should not be limited to restatement of incurred claims based on the reasons stated where we addressed the definition of earned premium.

Subsection D should be deleted unless the NAIC plans to recommend language for the payment, including premium credits, of actual rebates. Please see our comments in the section titled “*Eliminated Section*” below. If the NAIC does not include the eliminated Section 7, then the regulation should have a provision requiring that payment of rebates should only be required after a reasonable period of time, not less than thirty days, after the total rebate amount submitted under subsection C is approved for distribution. It should not contain a date certain. In addition, where rebates are “paid” through premium credits, the regulation should specifically permit them to be credited against premiums billed immediately after the “reasonable period” above. This language should recognize that there may be more than one premium period that would be offset.

ELIMINATED SECTION. METHODS OF PAYMENT OF MEDICAL LOSS RATIO REBATES

A section specifically allowing for the use of premium credits has been removed from the regulation; we urge that it be reinstated. It is critical to health plans that they be provided appropriate guidance on how these MLR rebates are to be paid and in what form. The NAIC is the appropriate body to make the recommendation how that should occur.

As was noted during NAIC’s PPACA Subgroup’s development of the Issue Resolution Documents that are outlined in the attachment to this letter, there are many issues that have been discussed, debated and resolved that have been omitted from the regulation without public discussion. We urge their re-inclusion in the regulation as a recommendation, based on the expertise of the state-based regulatory community, for appropriate handling of rebates. It is imperative that the industry be given appropriate and timely understanding of not only the mathematical calculation of the medical loss ratio that will lead to the determination of the total rebate amount, but of the entire standardized methodology relating to actual rebates. The elements of the numerator and denominator are critical components in determining the total rebate amount, but how the actual rebates are to be managed, to whom they are to be sent, in what format and when is just as critical to determining the methodology for implementing these new, and uniquely complicated, requirements.

SECTION 7. CREDIBILITY ADJUSTMENTS TO MEDICAL LOSS RATIO

We believe that a valid credibility adjustment is critical to maintain a vibrant market in the states. The existing credibility adjustment falls far short of what is needed to maintain competitive markets. Table 1 in Appendix A does not meet this requirement for blocks as small as 5,000 life years. Please refer to our comments under Appendix B.

There is no statutory basis for the provisions in subsection B to combine the results of 2011 and 2012 in situations where 2012 is not fully credible, but not combine them in other situations. The use of averaging starts January 1, 2014 and therefore can only apply to 2013 and later rebate calculations. As such, the wording in subsection B should match that in subsection A with 2012 replacing 2011, unless changes are also required for the next comment.

It is unclear whether the calculations required by Section 7 are to be before or after the adjustment to life years that would result for Sections 8.B, 9.B and 10.B. The IRD required the calculations to be after those adjustments, but a straight-forward reading of the regulation would not adjust life years for newly issued and deferred business.

SECTION 8. MEDICAL LOSS RATIO REBATE CALCULATION FOR PLAN YEAR 2011

The word “can” in Subsection 8.B. should be changed to “may.” Assuming that life years are to follow newly issued and deferred business, which, as noted above, is consistent with the relevant IRD, the definition of “experience” here and throughout the regulation should be: For purposes of this subsection, “experience” means all of the elements used to calculate the credibility adjusted loss ratio.

Subsection J should refer to the “total rebate amount” since this is not the amount to be paid to any specific group or individual.

SECTION 9. MEDICAL LOSS RATIO REBATE CALCULATION FOR PLAN YEAR 2012

Please see our comments regarding Section 8, above.

In a letter from the PPACA Actuarial Subgroup addressed to AHIP dated September 24, 2010 it was noted that ‘PPACA calls for rebate calculations in 2011 and 2012 that are based on the actual MLR in each year, and then switches to a three-year moving average in years 2013 and later.’ We agree with this statement. Therefore, 2012 should be based on the results of that year alone, regardless of the level of credibility of 2012 lives. Thus, Section 9 should be revised to match Section 8, differing only in the reference year and the need to include the experience for newly issued and deferred business from 2011 into 2012 experience.

In addition, we note that the resolution to IRD 006 determined that the loss ratio calculations should not double count rebates already paid. Yet the letter referenced above and attached to this comment letter also notes in its second paragraph the extent of potential double-counting in the rebate calculations for 2013 and 2014. It suggests that creating special rules for just the

individual line of business would solve the problem. This solution, unfortunately, cannot address an issue that applies to all lines of business. We note in addition that the letter suggested that double-counting is somehow justified; however, that is based on an erroneous view of what the appropriate result would be in situations where double-counting occurs. It is possible that a methodology for the rebate calculations can be developed that would be consistent with IRD 006; the NAIC should take the time and opportunity to do so.

SECTION 10. MEDICAL LOSS RATIO REBATE CALCULATION FOR PLAN YEAR 2013

See our comments on Section 8 Subsections B and J with reference to subsections B and K.

Subsection H should be removed. A large portion of the 2011 experience will be based on rates determined prior to the direction that will be provided by this regulation. The implication then is that the minimum loss ratio standard prior to any credibility adjustment will not be met for many blocks in 2011. But even those carriers that make their best efforts to meet the loss ratio requirements in their new rate filings are subject to a level of random variation that is beyond their control. In this case, there is a probability that at least one time out of four a company will not be able to apply the credibility adjustment for any block of business that is only partially credible. This makes it extremely difficult for companies with smaller blocks of business to maintain those blocks and to manage into the post-2014 environment. This only encourages market contraction and a decrease in consumer choice.

APPENDIX A: Formats for Reporting Rebate Calculations

The PPACA Actuarial Subgroup on a number of occasions advised that it would develop reconciliation from annual statement values to the supplement and then to the *Rebate Calculation Supplemental Form* (the rebate calculation form). This reconciliation will be critical and will need to take into consideration the following, at a minimum:

- Differences created due to the use of three-month run-off data – it is important that this run-off data be consistent for both numerator and denominator adjustments in order to ensure that calculations reflect actual experience. If claim reserves are reduced because a period of coverage during the experience year is not actually covered due, for example, to a coverage lapse that is only known during the run-off period, then both premiums and incurred claim reserves should be reduced. This is very different from the impact of including paid claims during these three months and reducing the claim reserve accordingly. Unless both earned premiums and incurred claims are similarly adjusted to reflect actual periods of coverage, the rebate calculation will be incorrect. Please see our additional comments under the definition of “Earned premium,” above.
- Reconciling items that are reported differently in the annual statement supplement and the rebate calculation form. These include payments and reserve changes for experience rated cases which are a portion of earned premiums in the annual statement but a part of incurred claims for the rebate calculation.

- Reflecting items that require different assumptions – the change in contract reserves in the Health Care Supplement is on the same basis as that used in the Annual Statement. This is not the appropriate reserve change for use in the rebate calculation. It is important to provide for revisions to both the assumptions (particularly morbidity and terminations) and the reserve method (allowing net level for the rebate calculation regardless of the method used in the annual statement) as appropriate and permitted, as part of the reconciliation. A carrier’s ability to maintain its individual book of business will depend upon this consideration.
- Reflecting adjustments due to dual contract, dual option and multi-state rated plans as allowed by the regulation.
- Reflecting the elimination of differences between 12/31/2010 accrual estimates and actual values during 2011. Since the rebate calculation uses only 2011 premiums and claims, the effect of adjustments related to 2010 experience that occurs during 2011 must be eliminated as part of the reconciliation or else the loss ratio will not be accurate at all. If the ratio, at its most basic concept is the amount of claims paid to premiums received, then it is critical that the premiums are only those attributable to 2011 and the claims are only attributable to 2011 as well. This applies to both earned premium elements and incurred claim elements. This should be addressed either in the regulation itself, in Appendix A, or in any future documents outlining appropriate reconciliation between the supplement, the rebate calculation form and the annual statement.
- Reflecting items not specifically identified in the Health Care Supplement, such as group conversion charges.

We assume that items 9 through 11 of the rebate calculation form are to be the change in accrual for 2011, as many of these items cannot be strictly allocated to claims incurred in 2011. Because of the critical importance of the contract reserve in rebate calculations that reflect the use of annual loss ratio calculations, as opposed to lifetime loss ratio calculations, the instructions for line 8 should specifically note that the use of net level contract reserves in the rebate calculation is allowed regardless of the reserve basis in the supplement.

The instructions for lines 1 through 4 of the rebate calculation supplemental form should allow for reporting values “as of” or “through” March 31 of the year following the plan year, as appropriate.

We also suggest that there be a place to show the rebate calculation on the worksheet and that two lines are added to explicitly show the MLR numerator and denominator. And, given that different states may have different definitions of large and small group, we suggest the appendices specifically provide a place for the carrier to note which definition is being used.

APPENDIX B: Credibility Tables

We again note our concern that the factors in Table 1 are too low for entities operating in multiple states with small partially credible blocks. This is particularly true when working from

a model that also does not incorporate large claim pooling. Large claim pooling not only addresses random variance, but also allows for pooling of costs of chronic credible claims across markets and entities. Rather than allocate these types of claims to each individual market, carriers will often price off of pooled claims. This practice keeps premiums manageable for members in less credible markets with a disproportionate amount of high cost chronic claims, and is consistent with the goals of insurance, and indeed with the goals of Section 2718 of the Public Health Service Act. We reiterate our concern that use of the factors in Table 1 will not allow these entities to achieve long term stable capital and surplus levels and puts consumer choice at risk.

APPENDIX C: Excerpts from the Supplemental Health Care Exhibit Instructions

We again urge that Appendix C be removed from the regulation. The language excerpted in the regulation has not been fully adopted, as noted above, and will with absolute certainty, be changed by the Health Reform Solvency Impact Subgroup, so its inclusion here is premature.

OMITTED ISSUE: TRANSITION

We note that the model regulation does not address the issue of transition between the 2010 market and the 2014 market when the majority of market reforms will become effective, and the MLR moves to a three-year average. The time between then and now is a critical one. As the PPACA Actuarial Subgroup recognized, there will be a need for transition for many plans in order to avoid significant market disruption. Despite recognizing the need for transition, however, the regulation is silent.

The existing market structure has many challenges during the transition until the exchanges begin operating. Of primary concern is the fact that the individual market will, in most states, continue to rely on the existing agent/broker system for distributing their products. And, given the lack of a personal coverage requirement until 2014, policies in the vast majority of states will also continue to be medically underwritten, which means that benefit costs will continue to vary significantly by policy duration.

The transition from current state minimum lifetime loss ratios to the new 80 percent minimum requires certain transition considerations. Current state-approved premiums are, in many cases, based on lifetime loss ratios below the ACA required level. Health plans have priced their policies to meet their individual state requirements and cannot immediately revise the assumptions and pricing that they implemented in 2009 for 2010 policies. In addition, the ability of carriers to reduce commissions may be significantly constrained by existing contracts with agents and brokers.

Moreover, premiums for policies issued in 2011 have already been developed, and will have to be filed with state insurance departments before the Secretary of HHS certifies the new MLR rules currently being developed by the NAIC. This creates a further challenge for health plans who are being asked to price policies based on rules that have not yet been finalized.

Beyond 2011, while it is possible that health plans will be able to make some changes to their cost structure for distributing coverage many carriers will continue to be reliant on the existing agent/broker system and will be constrained in their ability to make these changes at least until the exchanges come into place in 2014. We therefore urge that the NAIC include transition directly into the PPACA regulation.

Thank you for the opportunity to provide input and comments. Please do not hesitate to contact the undersigned if you have any questions or comments.

Sincerely,

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October 11, 2010

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Commissioner Sandy Praeger
Chairperson, Health Insurance and Managed Care (B) Committee
National Association of Insurance Commissioners

Re: “Regulation For Uniform Definitions And Standardized Rebate Calculation Methodology For Plan Years 2011, 2012, and 2013 Per Section 2718(b) Of The Public Health Service Act.” (“Draft Regulation”)

Dear Commissioner Praeger:

UnitedHealth Group appreciates this opportunity to provide these comments to the Health Insurance Managed Care (B) Committee of the National Association of Insurance Commissioners (“NAIC B-Committee”) regarding the proposed Draft Regulation.

At the outset, we would like to thank the members of the Accident & Health Working Group (“A&H Working Group”) on its efforts in preparing the Draft Regulation.

For brevity, we have not commented in this letter on all provisions within the Draft Regulation which we believe should be changed or modified. For example, we have excluded from this communication issues that we believe have either now or previously been raised by us as technical comments to the A&H Working Group, comments to the NAIC regarding the definition of activities that improve health care quality or matters that we believe may need to be addressed by the United States Department of Health Human Services (“HHS”). Rather, we have focused our comments in two general areas:

- (1) Policy Issues – these are provisions in the Draft Regulation that we believe should be modified or changed in order to more effectively further the stated quality and affordability goals of the Patient Protection and Affordable Care Act (the “Act” or “PPACA”).

- (2) Statutory Interpretation Issues – these are provisions in the Draft Regulation that we believe are inconsistent with the express provisions within the Act.

POLICY ISSUES

I. CREDIBILITY

Issue Statement	<p>The A&H Working Group properly recognized that Medical Loss Ratios (“MLR”) and rebates calculated on experience that is not fully credible would be, in their words:</p> <p style="text-align: center;"><i>[T]oo variable and subject to random fluctuations to be used for any purposes.</i></p> <p>[A&H Working Group, IRD 23]</p> <p>The A&H Working Group attempted to address this issue in the Draft Regulation by applying credibility factors for blocks of business below a certain size.</p> <p>Notwithstanding these efforts, the magnitude of the proposed credibility adjustment in Appendix B in the Draft Regulation does not adequately address random statistical fluctuation for: (i) very small blocks or (ii) situations where there is a significant and varying degree of credibility between competitors in marketplace. This specific concern was raised by Rowen B. Bell, Chairperson, American Academy of Actuaries, on behalf of the Academy, in its comments to the NAIC B-Committee with respect to the Draft Regulation:</p> <p style="text-align: center;"><i>We are somewhat concerned that the magnitude of credibility adjustments selected by the actuarial subgroup may not be sufficiently large enough to mitigate the risks faced by smaller blocks of business in an environment in which upside risk is returned to consumers via rebate.</i></p> <p>[Comment letter of the American Academy of Actuaries to NAIC B-Committee related to Appendix B in Draft Regulation dated 10/18/2010]</p> <p>We have provided an illustration below that demonstrates the problem when two insurers with significant and varying degrees of credibility each apply the same MLR without appropriate adjustment.</p>
Illustration	For an insurer with a large block of business in a state — say, 500,000 lives —

there is a relatively low variability of claims. Let us suppose that 25% of the time, claims will be 0.5% higher than expected; 50% of the time, claims will be about at the expected level; and 25% of the time, claims will be 0.5% lower than expected.

For an insurer with a smaller block of business – say 75,000 lives – the claim variability in comparison will obviously be higher. If the variability is 0.5% for 500,000 lives, as suggested above, then it is reasonable for purposes of this example to project 2.5% for 75,000 lives.

How does this difference in claim variability (0.5% versus 2.5%) between a large block and smaller block impact competition and consumers once rebates are applied?

Suppose that:

- Both insurers are subject to minimum loss ratio of 80%; and
- Both set pricing to an anticipated loss ratio of 80%

Large Block Pricing Hypothetical:

Scenario	Probability	Premium	Claims	Expenses	Rebates	Gain/(Loss)
High claims	25%	\$2,000	\$1,608	\$400	\$0	(\$8)
Normal claims	50%	\$2,000	\$1,600	\$400	\$0	\$0
Low claims	25%	\$2,000	\$1,592	\$400	\$8	\$0
Average of all scenarios		\$2,000	\$1,600	\$400	\$2	(\$2)

Small Block Pricing Hypothetical:

Scenario	Probability	Premium	Claims	Expenses	Rebates	Gain/(Loss)
High claims	25%	\$2,000	\$1,640	\$400	\$0	(\$40)
Normal claims	50%	\$2,000	\$1,600	\$400	\$0	\$0
Low claims	25%	\$2,000	\$1,560	\$400	\$40	\$0
Average of all scenarios		\$2,000	\$1,600	\$400	\$10	(\$10)

What the above illustration makes clear is that solely as a result of claim volatility (when combined with rebates) a carrier with a smaller block will incur significantly more losses than the more credible larger block competitor. This is because the smaller block will have to absorb its proportionally higher

	<p>loses (as result of claim volatility) in years where its it claim payments are higher than it anticipated but will not be able to keep its proportionally higher gains in those years where its claims payments are lower than it anticipated (as a result of rebates).</p>
<p>Adverse Impact on Consumers & Competition</p>	<p>The impact of this inherent advantage an insurer with a large block will have over an insurer with a smaller block will be:</p> <ul style="list-style-type: none"> • <u>Higher Rates</u> – Insurers with smaller blocks will be required to raise prices to a greater extent than insurers with larger blocks to offset the impact of random claim volatility combined with rebate requirements. • <u>Fewer Consumer Choices</u> (both products and plans) – Smaller block insurers will be forced to either consolidate their products (e.g. withdraw from either the HMO or insurance market) or withdraw altogether. • <u>More Insolvencies</u>
<p>Solution(s)</p>	<p><u>Option A:</u> National aggregation at the “health insurance issuer” level (as that phrase is defined in Section 2791 of the Public Health Service Act) or higher level.</p> <p>How would national aggregation at the health insurance issuer level work:</p> <ul style="list-style-type: none"> • MLR: the health insurance issuer (i.e. the individual legal entity) would aggregate experience across all of its licenses in all states irrespective of situs of contract for the purpose of determining its overall MLR for each business segment (e.g. large group). • Rebates Levels (percentage): would be determined at a state level and applied based on situs of contract, thus allowing individual states the option to set higher MLR percentage requirements pursuant to PPACA Section 2718(b) if they deem appropriate. <p>The option A solution could be applied to improve credibility for all segments (individual, small or large) or could be applied to a single segment (e.g. large group only). We believe that each segment would benefit from this approach. Notwithstanding, we have proposed for illustration purposes proposed edits to make this modification for the large group only segment.</p> <p><u>Option B:</u> Credibility Adjustments. Credibility Tables in Appendix “B” in the Draft Regulation should be modified to apply a <u>90% Confidence Interval</u>, consistent with the recommendation of the American Academy Actuaries, and set the full credibility adjustment factor threshold at .5% (currently “full credibility” is defined as circumstances where the tables yield an adjustment of less than 1%).</p>

Edits to the Draft Regulation Necessary for Option "A"	<p><u>Revisions to Section 7.A.</u></p> <p>In Section 7.A., insert a new paragraph (3), which shall read as follows:</p> <p>(3) For large group health plans, the life years recognized in (1) and (2) preceding shall be the number of life years for all of the health insurance issuer's large group health plan contracts in all states, regardless of situs of contract or how the large group health plan contracts are assigned to states pursuant to Section 5. Also, the weighted average plan deductible, if relevant, shall be determined for all large group health plans in the aggregate. Therefore, the same credibility adjustment shall apply to large group health plans in every state.</p> <p><u>Revisions to Section 7.B.</u></p> <p>In Section 7.B., insert a new paragraph (4), which shall read as follows:</p> <p>(4) For large group health plans, the life years recognized in (1), (2) and (3) preceding shall be the number of life years for all of the health insurance issuer's large group health plan contracts in all states, regardless of situs of contract or how the large group health plan contracts are assigned to states pursuant to Section 5. Also, the weighted average plan deductible, if relevant, shall be determined for all large group health plans in the aggregate. Therefore, the same credibility adjustment shall apply to large group health plans in every state.</p> <p><u>Revisions to Section 7.C.</u></p> <p>In Section 7.C., insert a new paragraph (3), which shall read as follows:</p> <p>(3) For large group health plans, the life years recognized in (1) and (2) preceding shall be the number of life years for all of the health insurance issuer's large group health plan contracts in all states, regardless of situs of contract or how the large group health plans are assigned to states pursuant to Section 5. Also, the weighted average plan deductible, if relevant, shall be determined for all large group health plan contracts in the aggregate. Therefore, the same credibility adjustment shall apply to large group health plans in every state.</p>
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Revisions to Section 8.

In Section 8, insert a new subsection F, and re-letter the current subsections F-J accordingly. The new subsection shall read as follows:

- F. Numerator adjustment for insurance coverage provided to large group health plans.
 - (1) An health insurance issuer that provides insurance coverage to large group health plans shall make an adjustment to its numerator calculation to reflect the medical loss ratio calculated for all states in aggregate, regardless of situs of contract.
 - (2) For any large group health plans for which adjustments have been made pursuant to Section 8.D. or Section 8.E., such adjustments shall be reflected in determining the adjustment made pursuant to this Section 8.F.
 - (3) The adjustment shall be an objective formula that is defined prior to January 1, 2011.
 - (4) The adjustment shall result in the health insurance issuer having the same medical loss ratio for large group health plans in each state for the plan year as the medical loss ratio calculated for large group health plans for all states in aggregate, regardless of situs of contract.

Revise subsection H (currently subsection G) as follows.

- H. The medical loss ratio is calculated as the unrounded ratio of the numerator in C, adjusted for conditions in D, ~~and E,~~ and F, to the denominator in G.

Revisions to Section 9.

In Section 9, insert a new subsection F, and re-letter the current subsections F-J accordingly. The new subsection shall read as follows.

- F. Numerator adjustment for insurance coverage provided to large groups.
 - (1) An health insurance issuer that provides insurance

coverage to large group health plans shall make an adjustment to its numerator calculation to reflect the medical loss ratio calculated for all states in aggregate, regardless of situs of contract.

- (2) For any large group health plans for which adjustments have been made pursuant to Section 9.D. or Section 9.E., such adjustments shall be reflected in determining the adjustment made pursuant to this Section 9.F.
- (3) The adjustment shall be an objective formula that is defined prior to January 1, 2012.
- (4) The adjustment shall result in the health insurance issuer having the same medical loss ratio for large group health plans in each state for the plan year as the medical loss ratio calculated for large group health plans for all states in aggregate, regardless of situs of contract.

Revise subsection H (currently subsection G) as follows:

- H. The medical loss ratio is calculated as the unrounded ratio of the numerator in C, adjusted for conditions in D, ~~and E,~~ and F, to the denominator in GF.

Revisions to Section 10.

In Section 10, insert a new subsection F, and re-letter the current subsections F-K accordingly. The new subsection shall read as follows.

- F. Numerator adjustment for insurance coverage provided to large groups.
 - (1) An health insurance issuer that provides insurance coverage to large group health plans shall make an adjustment to its numerator calculation to reflect the medical loss ratio calculated for all states in aggregate, regardless of situs of contract.
 - (2) For any large group health plans for which adjustments have been made pursuant to Section 10.D. or Section 10.E., such adjustments shall be reflected in determining the adjustment made pursuant to this Section 10.F.

	<p>(3) The adjustment shall be an objective formula that is defined prior to January 1, 2013.</p> <p>(4) The adjustment shall result in the health insurance issuer having the same medical loss ratio for large group health plans in each state for the plan year as the medical loss ratio calculated for large group health plans for all states in aggregate, regardless of situs of contract.</p> <p>Revise subsection H (currently subsection G) as follows.</p> <p>H. The medical loss ratio is calculated as the unrounded ratio of the numerator in C, adjusted for conditions in D, and E, <u>and F,</u> to the denominator in GF.</p>
<p>Edits to the Draft Regulation Necessary for Option “B”</p>	<p>Delete Table 1 from Appendix B, Credibility Tables and insert a revised Table based on 90% Confidence Interval and the full credibility adjustment factor threshold at .5%</p>
<p>Legal Authority</p>	<p>With respect to Option “A” the Groom Law Group and Alston & Bird have each rendered legal opinions confirming that the NAIC has the discretion under PPACA to determine Medical Loss Ratio based on aggregate experience of the health insurance issuer or across affiliates (attached hereto respectively as Exhibits “1” & “2”).</p> <p>Some consumer advocates have previously raised concerns about a different aggregation approach than contemplated above that combines experience of different legal entities. The consumer advocate’s primary contention was that aggregation across affiliates (either state or federal) is legally impermissible because it is inconsistent with the definition of “health insurance issuer.” We disagree with that conclusion but want to make clear that Option “A” does not call for aggregation across affiliates but rather aggregation is done at the health insurance issuer level.</p> <ul style="list-style-type: none"> • The term “health insurance issuer” means an entity “licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance.” [Public Health Services Act (“PHSA”) Section 2791] • Groom opinion: “PHSA Section 2791 merely sets forth the general definition of who is subject to the broad requirements of the PHSA as an <i>insurer</i> and the answer is that the entity must be licensed in at least one state but may be licensed in multiple states.”

	<p>Further, the Option “A” solution we have proposed affords individual states the flexibility to establish higher MLR standards, the other concern raised by consumer advocates with respect to prior aggregation proposals.</p> <p>With respect to Option “B”, we are not aware of any legal objections raised with respect to the NAIC’s discretion to include in its recommendation to HHS the currently proposed credibility adjustment factors. Since the Option “B” solution proposed above simply modifies the credibility factors currently proposed in the Draft Regulation the same explicit discretionary authority provided to NAIC in PPACA Section 2718 would equally apply to this modification.</p>
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II. REBATE RECIPIENT

Issue Statement	<p>The A&H Working Group through an open process soliciting input from industry, provider and consumer stakeholders concluded that the most appropriate recipient of rebates would be policyholders. In reaching this conclusion the A&H Working Group stated:</p> <p style="text-align: center;"><i>One of the efficiencies of group insurance is that a single premium is paid to cover a group of people. Issuers may have no knowledge of the amount contributed by each enrollee to this coverage, and consequently would not be able to calculate the rebate due to each enrollee. Plan documents not available to the issuer may also define enrollee contribution amounts and responsibilities.</i></p> <p>[See, A&H Working Group –Withdraw IRD019]</p> <p>Subsequently, the A&H Working Group was instructed to withdraw IRDs 13, 19, 32, 33, 56, 68, 71, 74 and 75 (all of which reflected the A&H Working Group’s position that rebates should be paid to policyholders) on the basis that NAIC staff concluded that the issue of to whom rebates should be paid was beyond the NAIC’s purview.</p> <p>Although, we do not concur with the NAIC staff’s conclusion that this issue is beyond the purview of the NAIC and believe that NAIC has discretion to address this issue in the Draft Regulation, we nevertheless have proposed a solution that would indisputably be within the NAIC’s authority and consistent with the prior policy conclusions of the A&H Working Group.</p>
Solution	<p>NAIC leadership should make an open policy recommendation to HHS to incorporate the recommendations made by NAIC in withdrawn IRDs 13, 19, 32, 33, 56, 59, 68, 71, 74 and 75 into the final regulation adopted by HHS.</p>

III. BROKER/AGENT COMMISSION

<p>Issue Statement</p>	<p>If some portion of producer commission expense is not removed from the MLR calculation, health insurance issuers (for solvency and competition reasons) may be forced to eliminate or cut commissions. The impact of these actions will inevitably be:</p> <ul style="list-style-type: none"> • <u>Less Service</u>. In particular, individuals and small groups may no longer be able to attain assistance from producers. While bigger small groups (e.g. 20+) and large groups may be able to attract producers at reduced commission levels or move to a service fee arrangement, it may not be financially feasible for producers to provide such services to individuals and groups under 20 lives; and • <u>Slower Expansion of Coverage under PPACA</u>. The expansion of coverage goals of PPACA hinges in large part on expanding coverage in individual and small group markets (the segment that will be most negatively impacted by cuts in commission); exchanges and online portals may over the longer term mitigate against this negative effect but in the near term expansion of coverage goals of PPACA will likely be adversely impacted. <p>The concerns noted above have been formally recognized by the NAIC in its Resolution adopted on August 17, 2010, entitled, <i>[T]o Protect the Ability of Licensed Insurance Professionals to Continue to Serve the Public</i>, wherein the NAIC expressly addressed the need to recognize and protect the role of the producers as standards for health care reform are developed. However, the NAIC has indicated that it feels constrained to take more direct action in the Draft Regulation to recognize the unique nature of commissions in the MLR calculation.</p>
<p>Solution</p>	<p>The NAIC should expand upon its August 17, 2010 Resolution (described above) and make an open policy recommendation to HHS that would support removal of a portion of producer commission expenses from the MLR rebate calculation.</p> <p>We believe that it would be appropriate to establish different levels for each segment as a result of the difference in gross premiums paid by policyholders and, consequently, would propose the following:</p> <ul style="list-style-type: none"> • 4% for individual business • 3% for small group • 2% for large group

	Under the above proposal, carriers could elect to pay more but any commission payments that exceed the established level would be counted toward the carrier's administrative costs.
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STATUTORY INTERPRETATION ISSUES

I. DEFINITION OF SMALL & LARGE GROUP

Issue Statement	<p>The A&H Working Group in the proposed Draft Regulation has defined "Small group health plan" and "Large group health plan" with a general reference back to the Public Health Services Act.</p> <p style="text-align: center;"><i>[A]s such term is defined in the Public Health Services Act.</i></p> <p>[Draft Regulation exposed by NAIC B-Committee on 10/5/2010]</p> <p>This general reference back to the PHSA for both of these important definitions was in reaction to objections raised to the original language proposed in the Draft Regulation released by the A&H Working Group which defined "Small group health plan" as 2 to 50 employees and "Large group health plan" as at least 51 employees.</p> <p>We believe that the newly proposed language is an improvement but believe that it is necessary and appropriate to provide more definitive guidance.</p>
Solution	The Draft Regulation should be modified to define "Small group health plan" as 1 to 100 employees and "Large group health plan" as a plan with at least 101 employees.
Edits to the Draft Regulation Necessary	<p><u>Revisions to Section 3A.</u></p> <p>In Section 3A, modify the definitions in (7) and (10) to read as follows:</p> <p>(7) "Large group health plan" means a health plan with at least 101 employees</p> <p>(10) "Small group health plan" means a health plan with 1 to 100 employees.</p>
Legal Authority	The term "small employer" is defined in PPACA in two separate provisions to mean an employer with at least 1 but not more than 100 employees. Section 1304(b) defines a "small employer" for purposes of Title I of PPACA to mean <i>"an employer who employed an average of at least 1 but not more than 100</i>

	<p><i>employees...”</i></p> <p>The PPACA also has a lengthy section titled “Conforming Amendments.” PPACA Sections 1563, 10107(b)(1). Section 1563(c)(16) amends PHSA Section 2791(e)(4), the definition of a “small employer.” Following the application of the section 1563(c)(16) amendments, the PHSA definition of a small employer is <i>an employer who employed ... at least 1 but not more than 100 employees.</i> PHSA Section 2791(e)(4) (as amended). Regardless of whether the governing ACA definition of a small group is the conforming amendment, as suggested by the NAIC in its MLR regulation, or by section 1304, as suggested by others, the result is the same. The definition of a small group for MLR purposes is groups of 1 to 100. We, however, understand that there has been some confusion about when the provisions apply as neither Sections 1304 or 1563 (c) (16) have effective dates. This confusion with respect to effective dates as a result of absence of an explicit effective date being set forth in the definitions sections is misplaced. There is no need for definitions sections to have effective dates. Definitions only provide explications as to terms used in other provisions of the law. The <u>effective date of those provisions</u> is what controls.</p> <p>The NAIC proposed Draft Regulation (exposed on October 5, 2010) defines small group health plan for MLR purposes by reference to the PHSA, suggesting the NAIC believes that the conforming amendment is the governing definition, since the conforming amendment amends the PHSA and section 1304 does not.</p> <p>Assuming this reading is correct, there should be no concern about applying the effective prior to 2014. The definition of small employer for purposes of the guaranteed issue rule for small employers and the small employer exemption for mental health parity purposes, <u>remain unchanged because the Section 1563 provision is explicitly a “conforming amendment”</u>. A “conforming amendment” necessitated by a new statutory requirement should be construed as making only those changes necessary to accommodate the new statutory requirement. <i>See Springdale Memorial Hosp. Ass’n, Inc. v. Bowen</i>, 818 F.2d 1377, 1386 n.9 (8th Cir. 1987) (citing <i>CBS, Inc. v. FCC</i>, 453 U.S. 367, 381-82 (1981), for the proposition that a “conforming amendment” should be construed merely as a “non-substantive reaction” to related legislation). Therefore, even if NAIC believes that section 1563 controls, it would appear that the definitions section applies as soon as the MLR calculations are law and that such definitional changes apply only to MLR.</p>
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II. LOSS ADJUSTMENT EXPENSE

Issue Statement	Section 2718(a) of the PHSA (as amended by PPACA) provides in pertinent part:
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	<p><i>A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary report concerning the ratio of incurred loss (or incurred claims) plus a <u>loss adjustment expense</u> (or change in contract reserves) to earned premiums.</i></p> <p>The A&H Working Group concluded in IRD001 that:</p> <p><i>[W]e find that the interests of all involved will be maximized in total by excluding the Loss Adjustment Expense from the numerator of the MLR rebate formula.</i></p> <p>While we agree that the NAIC has broad discretion in developing its recommendation, we do not agree that the NAIC has unlimited discretion to ignore express statutory provisions by effectively giving them no meaning.</p> <p>We have attached hereto a legal opinion by the national law firm of Alston & Bird, LLP (see attached, Exhibit “4”) wherein the firm concluded that a “plain reading” of the statute and the normal application of statutory construction principles would require an interpretation that “loss adjustment expense” should be included in the numerator and denominator in the MLR rebate calculation and that it should be interpreted consistent with NAIC SSAP No. 55.</p>
Solution	The NAIC should modify the Supplemental Health Care Exhibit and Draft Regulation to allow for inclusion in the numerator of the MLR calculation “loss adjustment expenses” as that phrase is defined in NAIC SSAP No. 55
Legal Authority	PPACA Section 2718. See attached, Legal Opinion from Alston & Bird, LLP (Exhibit “3”).

III. TAXES

Issue Statement	The A&H Working Group has adopted the definition of “Federal and State taxes” applied by the NAIC in Appendix C from the Supplemental Health Care Exhibit on 8/17/2010. We believe that this definition is inconsistent with PPACA Section 2718 in that it improperly excludes taxes on investment income and capital gains
Solution	The NAIC should modify the definition in both the Draft Regulation and Supplemental Health Care Exhibit and delete the exclusion for federal income taxes on investment income and capital gains.
Edits to the Draft	To delete exclusion for federal income taxes on investment income and capital gains.

Regulation Necessary	<p><u>Revisions to Section 3A.</u></p> <p>>In Section 3A, Subsection 1, modify definition as follows:</p> <p>(1) “Federal and State taxes and licensing or regulatory fees” means those taxes and licensing or regulatory fees as defined in Appendix C.”</p> <p><u>Revisions to Appendix C.</u></p> <p>>Delete: “Excerpts from the Supplemental Health Care Exhibit Instructions”</p> <p>>Delete: “Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART I</p> <p>>Delete: In Line 1.5, “Exclude: Federal income taxes on investment income and capital gains.”</p>
Legal Authority	With respect to the proper treatment of taxes on investment income and capital gains under PPACA Section 2718; see attached, legal opinions from Alston & Bird (Exhibit “4”), The Groom Law Group (Exhibit “5”), and Steptoe & Johnson (Exhibit “6”).

CONCLUSION

Again, we would like to thank the NAIC B-Committee for providing us this opportunity to comment.

Sincerely,


Nick Thompson
Senior Vice President, Regulatory Affairs
UnitedHealth Group

CNT/jmm
Enclosures



October 6, 2010

Commissioner Sandy Praeger
Chair, Health Insurance and Managed Care (B) Committee
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

CC: Jolie Matthews, Brian Webb, Leslie Jones

Re: Application of Medical Loss Ratio Requirements enacted in the
Patient Protection and Affordable Care Act (ACA) to International Health Plans

Dear Chairwoman Praeger:

We are writing to provide comments on the implementation of the Medical Loss Ratio (MLR) requirements in the new Section 2718 of the Public Health Service Act, as amended by the Affordable Care Act (ACA).

Our company provides health coverage to individuals who live, study, travel or work abroad. We are very concerned about the potential impact of the new MLR requirements on these unique specialty products.

HTH Worldwide is a leading provider of international health insurance programs and an innovator in online healthcare information, medical assistance and insurance services around the globe. HTH invests in the development of unique products and assets to assist the global traveler, including a directly contracted international network of 7,000 medical practitioners and facilities in over 180 countries outside the United States. HTH is a leading provider of insurance programs for international students studying in the USA as well as American students studying abroad. We also provide services and insurance programs to expatriates, business and leisure travelers. International health plans and services are our only lines of business.

While it is not clear that Congress intended to apply ACA's coverage provisions to individuals studying, living, traveling or working abroad, we note that ACA requires that the MLR methodologies "shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans." Health plans offering coverage to individuals studying, living, traveling or working abroad clearly operate under special circumstances not experienced in the domestic insurance market and should be granted relief from MLR regulations.

International health insurance programs and related services are materially different than domestic health insurance programs due to the broad scope of efforts required to identify customers and provide access to quality healthcare to them around the globe. To meet the healthcare needs of individuals traveling abroad, it is simply not possible for international plans to conform to an 80 percent or 85 percent MLR. These plans are sold to expatriates and require unavoidably higher sales and administrative costs associated with doing business abroad. Preserving the availability of quality medical insurance for individuals who travel abroad for work or personal reasons is an important component of a comprehensive insurance market. To preserve the availability of these products in the US, we believe that plans providing coverage to individuals and companies with families living, traveling, studying or working abroad deserve special consideration.

Attached are previous letters submitted by HTH Worldwide to HHS and the NAIC that provide greater detail about the unique business requirements and benefits of international plans and why they deserve special consideration. We applaud the NAIC Accident and Health Subgroup for its extensive work developing IRD #35, which defines international plans and accurately describes their special requirements. Consistent with IRD #35, we urge that the NAIC recognize, in their MLR recommendation letter to The Department of Health and Human Services, the special nature of these plans by recommending to Secretary Sebelius that international plans, as defined in IRD 35, be exempted from ACA or at a minimum, exempted from the MLR requirements of ACA.

We appreciate your serious consideration of our unique circumstances and the valuable role global health plans play in the insurance market. We would be happy to answer any questions you may have and to provide you with additional information on the nature of international plans.

Sincerely,

A handwritten signature in black ink, appearing to read 'AM', with a long horizontal flourish extending to the right.

Angelo Masciantonio
Chief Executive Officer
HTH Worldwide
610-254-8701
amasciantonio@hthworldwide.com



May 14, 2010

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Application of the Patient Protection and Affordable Care Act (PPACA) to group and individual health plans specifically created for individuals while traveling, studying and living outside their home country

Dear Secretary Sebelius:

We are writing to provide comments on the potential impact of implementation of the PPACA on health plans specially created for individuals who are living, working or studying abroad.

Safeguarding Individuals Abroad

Each year, individuals circle the globe pursuing their business, education, leisure and lifestyle goals. For example:

- Americans take over 50 million trips outside the country for business and leisure
- Over 5.25 million Americans live abroad as expatriates
- Hundreds of thousands of students study abroad each year

All of these travelers deserve the peace of mind that comes from knowing they have access to quality care anywhere and at anytime.

HTH Worldwide is a leading provider of international health insurance programs for this population. We are an innovator in online healthcare information, around-the-clock medical assistance and insurance services around the globe. At present, HTH annually provides health insurance products or services to over 650,000 individuals who travel, study or live outside of their home country, including student, leisure and business travelers. HTH invests in the development of unique products and assets to assist the global traveler, including a directly contracted international network of medical practitioners and facilities in over 180 countries outside the United States. International health plans and services are our primary lines of business.

Preserving the availability of quality health insurance for individuals who travel abroad for work or personal reasons is an important component of a robust insurance market. To preserve the availability of these products in the U.S., we believe that plans providing coverage to individuals living, traveling or working abroad warrant an exemption from PPACA provisions.

Application of PPACA to Global Health Plans Created for International Travelers

It appears that the insurance market reforms enacted in PPACA are directed at group and individual plans sold in the U.S. domestic health insurance market. No consideration appears to have been given to the detrimental impact of applying the Act's requirements to plans and services created to safeguard individuals traveling, living, studying or working abroad. We contend that Section 2718 (relating to medical loss ratios) in the Public Health Service Act ("PHSA") and PPACA in general, were not intended to apply to group and individual plans sold to individuals living, working, studying or traveling abroad.

Global benefit plans are 1) designed with additional high-cost features required to meet the unique needs of individuals living, working, studying and traveling abroad; 2) tailored to each destination country; and 3) include support services, such as coverage of medical evacuation and translation services, that are not found in domestic health plans. For this reason, employers often carve out their employees working abroad from their domestic plans or purchase supplemental coverage. In addition, **Medicare and Medicaid do not cover beneficiaries when they leave the country.** The U.S. State Department in fact references this gap in coverage at http://travel.state.gov/travel/cis_pa_tw/cis/cis_1470.html.

We also seek clarification on the treatment of inbound foreign student health plans offered by U.S. insurers. The U.S. Department of State requires these students and trainees to maintain health insurance coverage that meets certain minimum standards set by law. These standards are designed to meet the unique needs of foreign students and trainees while they are in the U.S. Today, there are plans available for inbound students and trainees at a very affordable price. This provides visiting students with coverage for health care services in the U.S. and coverage for the cost of repatriation in the event of more serious medical needs. Access to these plans is important for visiting students and trainees who will not benefit from PPACA's extension of dependent coverage to age 26 and who likely could not afford PPACA mandated individual plans. Requiring U.S. carriers to meet the PPACA requirements, including MLR, likely will force these plans out of the market. We believe it is important to preserve this lower-priced option for visiting foreign students and trainees to assure that a U.S. education is within their reach.

In addition, if PPACA is interpreted to include expatriate, visiting foreign student and travel health insurance policies, they will become the exclusive province of international and non-admitted insurers who can tailor their plans to this specialty market segment's needs without complying with PPACA standards which do not take into account the services, coverage and cost structures of expatriate and travel health insurance programs.

The PHSA identifies certain types of benefits that are not subject to certain PHSA requirements – so-called "excepted benefits" (42 U.S.C. 300gg-91 (c)). To the extent of the Secretary's authority, we urge the Department of Health and Human Services to exercise its authority under the PHSA to add specialty benefit plans for individuals traveling, living, working, or studying abroad to the category of excepted benefits and to consider the special circumstances of international plans in future regulatory guidance.

Medical Loss Ratio

If the Department concludes, however, that such specialty benefit plans should be subject to the requirements of PPACA, we believe that they warrant special consideration, particularly with respect to the application of the MLR under Section 2718. Section 2718 requires the National

Association of Insurance Commissioners (NAIC) to establish “methodologies (for calculating the MLR) designed to **take into account the special circumstances of smaller plans, different types of plans** and newer plans.” The unique demands of international health insurance plans appear to fit squarely into the category of plans requiring special consideration.

We respect the positive intent of the new statutory MLR requirements provided in section 2718; unfortunately, to meet the health needs of individuals traveling abroad, it is simply not possible for international plans to conform to an 80 percent or 85 percent MLR. The expense of providing access to and coordinating health care around the world is substantially higher than in the United States. For example, to immediately meet the needs of an expatriate working in China or Japan, our member support lines must be open 24 hours/day, 365 days/year versus just 40 hours a week for a domestic health plan, a fourfold increase in baseline expense. We also have to maintain case management and claims processing employees who speak multiple languages and help navigate cultural and health related issues in 200 countries. This level of expertise is necessary not only to help members and providers to communicate effectively, but also because we often act as the intermediary between local hospitals, physicians, clinics, ambulance services, etc., that are not prepared to deal with U.S. methods of treatments, protocols and payments.

Managing health care outside the U.S. is sometimes a daunting and challenging task. Expatriates can often become ill very rapidly in areas with little to no quality medical care available, and we must take the responsibility of assessing the care available in each location and transporting the members to a location where they can receive adequate medical care immediately. Maintaining the infrastructure and highly trained personnel to manage these difficult cases can be extremely costly, especially if a medical evacuation is involved. If the cases are not managed appropriately, it can result in increased medical risk to a member or even death.

In addition, developing and maintaining a global network of contracted, qualified foreign care givers (in 180 countries) is much more costly and burdensome than developing a domestic network. The expense of administering a worldwide provider network, managing currency risks and paying for care outside the U.S., where there are no widely recognized or standardized systems or even nomenclatures for diagnosis, treatment or billing, is substantially higher. This lack of global standardization prevents international health plans from implementing electronic submission and auto-adjudication of claims, thus limiting our ability to achieve the efficiencies that domestic plans currently enjoy on the overwhelming majority of their claims. Also, we must execute banking arrangements to pay caregivers in over 100 currencies across all time zones. For all of these reasons, the costs of administering overseas care can be approximately three to four times higher than domestic health insurance administrative costs.

We have attached our full letter to the NAIC detailing the reasons why these specialty insurance plans deserve an exemption from Section 2718 of the PHS Act (MLR). At a minimum, we request that the Department develop MLR regulations that provide for significantly lower medical loss ratios that take into account the special circumstances and needs of plans covering individuals traveling, living, studying or working abroad.

Summary

We believe that the insurance market reforms enacted in PPACA are directed at group and individual plans sold in the U.S. domestic health insurance market. No consideration appears to have been given to the detrimental impact the Act's requirements will have on plans and

services designed to safeguard individuals traveling, living, studying or working abroad. Employers who sponsor or individuals who buy these plans shop in a global marketplace. PPACA's minimum benefit requirements are not applicable to foreign insurers (i.e. non-admitted policies). Requiring U.S.-based international health insurers to adhere to rules and requirements governing domestic health plans will significantly increase the cost of our products relative to our foreign competitors, driving international and expatriates to buy less expensive and, in all probability, non-compliant offshore foreign policies.

We would be happy to discuss this with you further to provide you with additional information on our plans and plan expenses. Thank you very much for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read 'AM', with a stylized flourish extending to the right.

Angelo Masciantonio
Chief Executive Officer
HTH Worldwide
610-254-8701
amasciantonio@hthworldwide.com



May 11, 2010

Mr. Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup

Mr. Steven Ostlund
Chair, Accident & Health Working Group
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

Re: Application of Medical Loss Ratio Requirements enacted in the
Patient Protection and Affordable Care Act (PPACA)

Dear Mr. Felice:

We are writing to provide comments on the implementation of the Medical Loss Ratio (MLR) requirements in the new Section 2718 of the Public Health Service Act, as added by PPACA.

Background

HTH Worldwide is a leading provider of international health insurance programs and an innovator in online healthcare information, medical assistance and insurance services around the globe. At present, HTH annually provides health insurance products or services to over 650,000 individuals who travel, study or live outside of their home country, including student, leisure and business travelers. HTH invests in the development of unique products and assets to assist the global traveler, including a directly contracted international network of medical practitioners and facilities in over 180 countries outside the United States. International health plans and services are our only lines of business.

Our company provides health coverage to individuals who live, study, travel or work abroad. We are very concerned about the potential impact of the new MLR requirements (and other provisions in PPACA) on these unique specialty products. Preserving the availability of quality medical insurance for individuals who travel abroad for work or personal reasons is an important component of a robust insurance market. To preserve the availability of these products in the US, we believe that plans providing coverage to individuals living, traveling or working abroad deserve special consideration.

“Methodologies for Special Circumstances”

Section 2718(c) states that the National Association of Insurance Commissioners (“NAIC”) shall establish “methodologies (of calculating MLR) designed to take into account the special circumstances of smaller plans, different types of plans and newer plans.” The unique demands

on international health insurance plans appear to fit squarely into the category of plans requiring special consideration.

We respect the positive intent of the new statutory MLR requirements provided in section 2718; unfortunately, to meet the health needs of individuals traveling abroad, it is simply not possible for international plans to conform to an 80 percent or 85 percent MLR. Our global health insurance plans offer lower per member per month (pmpm) premiums (typically ranging from \$130 to \$300 pmpm versus up to \$500 pmpm for primary domestic coverage), but these expatriate plans also require unavoidably higher sales, distribution and administrative/loss adjustment costs associated with doing business abroad. Forcing these unique plans to conform to the proposed MLR will 1) hinder our ability to offer low-premium and high-quality plans to our customers and 2) put us at a competitive disadvantage against non-admitted international health plans, which will not be subject to state or federal standards.

The expense of providing access to and coordinating health care around the world is substantially higher than in the United States. For example, to immediately meet the needs of an expatriate working in China or Japan, our member support lines must be open 24 hours/day, 365 days/year versus just 40 hours a week for a domestic health plan, a fourfold increase in baseline expense. We also have to maintain case management and claims processing employees who speak multiple languages and help navigate cultural and health related issues in 200 countries. This level of expertise is necessary not only to help members and providers to communicate effectively, but also because we often act as the intermediary between local hospitals, physicians, clinics, ambulance services, etc., that are not prepared to deal with U.S. methods of treatments, protocols and payments.

Managing health care outside the U.S. is sometimes a daunting and challenging task. Expatriates can often become ill very rapidly in areas with little to no quality medical care available, and we must take the responsibility of assessing the care available in each location and transporting the members to a location where they can receive adequate medical care immediately. Maintaining the infrastructure and highly trained personnel to manage these difficult cases can be extremely costly, especially if a medical evacuation is involved. If the cases are not managed appropriately, it can result in increased medical risk to a member or even death.

In addition, developing and maintaining a global network of contracted, qualified foreign care givers (in 200 countries) is much more costly and burdensome than developing a domestic network. The expense of administering a worldwide provider network, managing currency risks and paying for care outside the U.S., where there are no widely recognized or standardized systems or even nomenclatures for diagnosis, treatment or billing, is substantially higher. This lack of global standardization prevents international health plans from implementing electronic submission and auto-adjudication of claims, thus limiting our ability to achieve the efficiencies that domestic plans currently enjoy on the overwhelming majority of their claims. Also, we must execute banking arrangements to pay caregivers in over 100 currencies across all time zones. For all of these reasons, the costs of administering overseas care can be approximately three to four times higher than domestic health insurance administrative costs.

Expatriate plan benefits are created with additional services designed to meet the unique needs of individuals living and working abroad. These plans are tailored to each destination country and include support services not included in U.S.-based health plans, such as coverage of political and medical evacuation services. Building and maintaining a truly global platform for member services requires comprehensive online and mobile databases and tools for finding

appropriate doctors, hospitals, pharmacies and medications, as well as translating medical terms and phrases. These are unavoidable medical management costs for international health plans.

Other business requirements intrinsic to specialty international plans often include the need to pay for fronting fees and reinsurance. Worldwide insurance operations can require flexible business partnerships that do not neatly conform to U.S. health benefits standards. These additional costs will penalize specialty programs if PPACA's rules are deemed to apply.

As stated above, PPACA charges the NAIC with the task of establishing uniform definitions of clinical services and activities that improve health care quality and developing standardized methodologies for calculating measures of such activities, including definitions of which activities qualify. While it is not entirely clear that Congress intended to apply PPACA's coverage provisions to individuals living, traveling or working abroad, to the extent that they do, we note that PPACA requires that the MLR methodologies "shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans." Health plans offering coverage to individuals living, traveling or working abroad clearly operate under special circumstances not experienced in the domestic insurance market and should be candidates for relief from MLR regulations.

We hereby request that the NAIC recommend to the U.S. Department of Health and Human Services an exemption from Section 2718 for health plans that serve individuals living, working, studying or traveling abroad, because of the plans':

- Lower premiums
- Higher distribution costs
- Higher loss-adjustment and case management expenses
- Volatile and challenging cases serviced on a global basis
- Additional high cost member services and tools

In the alternative, at a minimum, we request that the NAIC recommend the establishment of significantly lower MLRs that take into account the special circumstances of health plans for individuals traveling, living or working abroad and a special methodology for global plans that permits the inclusion of our higher costs that are inextricably linked to providing immediate medical care abroad as clinical costs in the MLR. Furthermore, we agree with the comments submitted to NAIC by others that the term "clinical services" should be based on NAIC's definitions of claims and claims-related expenses in its various statutory accounting standards as permitted medical costs, and, should include: 1) reimbursements to health care providers; 2) payments to third parties; 3) other categories of provider payment; and 4) incurred-loss plus loss adjustment expenses (as enumerated in SAP 85).

Because HTH is a specialty insurance provider which only provides products and services to international travelers and expatriates, we do not have the capability to blend or offset our higher administrative costs with domestic business where these costs are lower. Placing us under the same MLR restrictions as domestic plans could make these products unaffordable, unsustainable and uncompetitive in the global marketplace. Consequently, it is of utmost importance to us that NAIC use their discretion to take into account special circumstances of different types of plans such as plans offering coverage to individuals traveling, living, studying or working abroad.

We appreciate your serious consideration of our unique circumstances and the valuable role global health plans play in the insurance market. We would be happy to discuss this with you further and to provide you with additional information on our plans and plan expenses.

Sincerely,

A handwritten signature in black ink, appearing to read 'AM', with a long horizontal flourish extending to the right.

Angelo Masciantonio
Chief Executive Officer
HTH Worldwide
610-254-8701
amasciantonio@hthworldwide.com



ASSURANT
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October 8, 2010

Commissioner Sandy Praeger
Chairperson, Health Insurance & Managed Care (B) Committee
National Association of Insurance Commissioners
2301 McGee Street, Ste. 800
Kansas City, MO 64108

Re: Draft Medical Loss Ratio Regulation

Dear Commissioner Praeger:

On behalf of Assurant, I would like to thank you and the NAIC B Committee for the opportunity to comment on the exposed draft medical loss ratio regulation.

Assurant would like to focus your attention on a particular issue that is a major concern with the regulation – the potential for carriers to overpay rebates in excess of the 80% MLR requirement for the individual and small group markets under the Patient Protection and Affordable Care Act (PPACA).

Under the existing regulation, rebates starting in 2013 will be determined using three year averaging of experience. This results in rebates for 2013 using experience from 2011 - 2013 and rebates for 2014 using experience from 2012 – 2014 with each year receiving partial weighting. However, the rebates for 2011 and for 2012 are calculated on a stand-alone basis without the benefit of any averaging and are based on the full difference between the MLR standard and the plan year experience, i.e., at 100% weighting. This would result in the consumer receiving the full value of 80% as outlined in PPACA for those years. To use the 2011 and 2012 experience again without including the rebates already paid, would result in subjecting the carrier to additional penalties for those years in which the full value was already provided via benefits and rebates.

The following example should help clarify this. Assume a carrier had a 76% MLR in 2011, 78% in 2012 and 80% in 2013. The rebates for 2011 and 2012 would be 4% and 2% respectively,

Assurant Health markets products underwritten by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

generating a total consumer value at the PPACA MLR target of 80% for each year. One would reasonably expect that the rebate for 2013 would be 0. However, the rebate for 2013 would be 2% due to the averaging of 2011 – 2013 and exclusion of 2011 and 2012 rebates. This generates a net result of 82% in 2013 driven by the rebate methodology and not underlying experience, effectively penalizing the carrier again for 2011 and 2012 experience. (This phenomenon would also occur in 2012 for situations where business was only partially credible in 2012 as under the proposed regulation, 2011 and 2012 would be averaged to increase credibility). This clearly cannot be what was contemplated under PPACA and must be changed in the MLR proposed regulation.

The Accident & Health Working Group PPACA Subgroup identified this concern during their work in Issue Resolution Document 6 and specifically concluded that calculation of rebates should not double count prior rebates. In coming to this conclusion, the subgroup stated in the document:

“The law specifies the level of MLR that will dictate a rebate. The excess premium is to be returned to the policyholder as a rebate. If a company were to be subject to “double jeopardy” by not considering previous refunds, the result would be nonsensical. Consider the case where an individual pool generated a fifty percent MLR. A thirty percent rebate would be required. If the calculation of a later period were to ignore the previous rebate, then the thirty percent rebate would be repeated resulting in the company having paid out 110% of premium for that year, 50% in claims, 30% for first rebate, and 30% for second rebate”.

While the issue was recognized by the subgroup, the problem has not been resolved in the existing draft MLR regulation.

This issue is further exasperated by carriers’ inability to appropriately price products for 2011 due to natural lag time for rating. With rate development, filings, notice to policyholders and a 12 month rate period, products were priced prior to the enactment of PPACA without consideration of the 80% MLR. Thus the potential for a lower MLR and payment of a rebate in 2011 (and to a lesser degree in 2012) is greater than if actuaries had sufficient time to react to the MLR change. Accordingly, the failure to include the 2011 and 2012 rebates in subsequent rebate calculations compounds the impact of carriers’ inability to immediately respond to the new MLR requirement.

For the above reasons, Assurant respectfully requests that the regulation be changed to add in paid rebates for 2011 and 2012 plan years when using prior years for weighted average calculations in 2012 - 2014. As experience from plan years 2013 and later will not be used on a

Page 3

stand-alone basis to calculate rebates but will always be part of a three year average, it is not necessary to include rebates for those years in subsequent weighted average MLRs.

Sincerely,

A handwritten signature in black ink, appearing to read "Brian Rees", with a long horizontal flourish extending to the right.

Brian Rees

Vice President, Valuation Actuary

Brian.rees@assurant.com

T 414.299.6877

F 414.299.7943



Kaiser Foundation Health Plan, Inc.
Program Offices

October 11, 2010

Honorable Sandy Praeger, Chair
NAIC Health Insurance and Managed Care (B) Committee
c/o Kansas Department of Insurance
420 S.W. 9th Street
Topeka, Kansas 66612-1678

VIA E-MAIL

RE: Medical Loss Ratio (MLR)

Dear Commissioner Praeger:

I am writing on behalf of the Kaiser Permanente Medical Care Program (“Kaiser Permanente”). Kaiser Permanente is America’s largest private integrated health care delivery system, which both directly provides health care services (through 36 hospitals, 431 medical offices, 164,000 employees, most of whom are involved in the provision of health care services, and 14,600 physicians) and organizes the financing of care for its members. It comprises: Kaiser Foundation Health Plan, Inc. (and its subsidiaries, collectively “Health Plan”), the nation’s largest not-for-profit health plan; the nonprofit Kaiser Foundation Hospitals (and its subsidiaries, collectively “Hospitals”); and the Permanente Medical Groups (“Medical Groups”), eight independent physician group practices that Health Plan contracts with to meet the health needs of Kaiser Permanente’s 8.6 million members in nine states and the District of Columbia. In addition, the substantial majority of ambulatory and hospital care, most pharmacy, diagnostic, and laboratory services are performed within Kaiser Permanente by Health Plan, Hospitals or Medical Groups employees in Health Plan or Hospitals-owned facilities.

We greatly appreciate the considerable time, effort and expertise the Accident & Health Working Group PPACA Subgroup (“Subgroup”) put into developing the *Regulation for Uniform Definitions and Standardized Rebate Calculation Methodology for Plans Years 2011, 2012 and 2013 Per Section 2718(b) of the Public Health Service Act* (“Regulation”). Our comments, which we view as primarily technical, address the integration of the definitions from the NAIC *Supplemental Health Care Exhibit* (“Supplement”) into the Regulation.

We note in the Regulation that many definitions are pulled directly from the Supplement, which we believe is appropriate. The Health Reform Solvency Impact (E) Subgroup, along with many regulators and interested parties, spent countless hours carefully crafting the definitions for the Supplement. They also were careful to mirror wherever possible existing definitions in the Annual Statement instructions to minimize disruption and

confusion. We are concerned, however, that the Supplement's instructions are not incorporated consistently throughout the Regulation. We urge you to ensure that the Regulation mirrors the terms and definitions from the Supplement unless there is a specific need to deviate from them, such as to capture the additional three month run out period for the payment of incurred claims within the reporting period.

We are particularly concerned about the Regulation's definition of "incurred claims." We greatly appreciate the Supplement's recognition of our integrated model and the critical need for the numerator of any MLR calculation to include the full costs of Kaiser Permanente's delivery system in addition to the costs of claims submitted by outside providers. Most services provided by Kaiser Permanente are not claims-based. What appear as "claims" to most insurance companies are usually experienced by our organization as direct health care services that we have provided. Claims are submitted only by outside providers.¹ Additionally, Health Plan itself is a health services provider that operates medical offices, pharmacies, and other facilities related to the delivery of health care services. Thus, unlike health insurers, Health Plan has expenses for delivering health care and for operating and maintaining its care delivery infrastructure.

Part 2, Line 2 of the Supplement's instruction, which defines "direct claims incurred" and mirrors the Annual Statement instructions, captures all of our medical expenses, both outside provider claims and those related to directly providing care and operating our health care delivery system. This definition does not seem to be captured in the Regulation's definition of "incurred claims" or "direct paid claims," which both refer only to paying claims, not providing care directly. It is critically important for integrated delivery systems like Kaiser Permanente that the Regulation also account for the full costs of providing care, not just paying claims. We ask that the Supplement's definition for "direct claims incurred" be incorporated into the Regulation's definition of "incurred claims." This could be accomplished in several ways, such as direct reference to Part 2, Line 2 of the Supplement or by using the Supplement's definition of "total incurred claims" in Part 1, Line 5.0, which incorporates Part 2, Line 2.

Recommendation:

While any explicit inclusion of our full medical expenses is acceptable, perhaps the simplest way is to amend the Regulation's definition of "direct paid claims" as follows:

(7) "Direct paid claims" means ~~claim payments~~ claims paid, as defined in Part 2, line 2 of the NAIC Supplemental Health Care Exhibit, before ceded reinsurance and excluding assumed reinsurance except as follows . . .

¹ Kaiser Permanente Regions in which Hospital owns hospitals also have large multispecialty Permanente Medical Groups, and thus claims are only a small fraction of the total medical costs in these Regions. These Regions are Northern and Southern California, Northwest and Hawaii; and they collectively serve 84 percent of Kaiser Permanente members nationwide. (Data as of December 2009). In the other Regions, which are relatively small, claims constitute a larger portion of total medical expense. Even so, claims alone are a very incomplete picture of the services we provide even in our non-hospital-based Regions.

Thank you for consideration of our comments. We welcome the opportunity to discuss these matters with you further. If you have questions or concerns, please contact me at julie.h.stoss@kp.org or (510) 271- 6430.

Sincerely,

A handwritten signature in black ink, appearing to read "Julie Stoss". The signature is fluid and cursive, with a long horizontal flourish at the end.

Julie Hutcherson Stoss
Vice President, Government Relations