



June 2, 2010

Subject: ACHP Comments on Blanks Proposal

Dear Mr. Felice and Mr. Sells:

The Alliance of Community Health Plans, whose members are community-based and regional health plans that are not-for-profit organizations or subsidiaries of not-for-profit health systems, appreciates the opportunity to submit additional comments on the Medical Loss Ratio (MLR) Blanks Proposal dated May 27, 2010.

Community Benefit Expenditures (currently Line 1.7 Instructions)

ACHP has previously submitted comments on the issue of community benefit expenditures that are incurred by tax-exempt entities. The 5/27 Blanks Proposal included recognition of these expenses as part of the instructions for Line 1.7. We believe the language is unnecessarily limiting and also should be moved to another line.

The IRS has defined a set of community benefit activities for purposes of reporting expenditures by tax-exempt entities on IRS Form 990. We suggest that the NAIC should reference the IRS definition as the appropriate description for purposes of the MLR calculation. Accordingly, we recommend the following change to the language in the 5/27 draft (new language in red and underscored):

Include: Payments for community benefit expenditures as defined by the IRS in Schedule H of Form 990, allocated by Health Premiums Earned ~~in lieu of premium tax but limited to the state premium tax rate.~~

Also, because community benefit expenditures derive from requirements of federal tax law, we believe that the subtraction for community benefit more properly belongs in the instructions for Line 1.5 rather than Line 1.7. If the subtraction for community benefit remains on one of the lines for taxes and assessments paid to the state, Line 1.6 for state and local insurance taxes and assessments would be more broadly applicable placement than Line 1.7 for state and local premium taxes.

Line 1.6 – State and Local Insurance Taxes and Assessments

We would like to reiterate a recommendation made earlier, that the last line in the instructions for Line 1.7 (on p. 7 of the 5/27 draft) which currently reads “State income taxes other than premium taxes” should be modified as follows:

State and local income, excise, and business taxes other than premium taxes.

State and local jurisdictions may impose excise and business taxes on gross receipts from engaging in business activities within the jurisdiction, separate from income taxes. The language providing for subtraction of taxes from premium revenue should be broad enough to capture all of the taxes, assessments, and fees that health plans are required by states and other authorities to pay.

Thank you for your consideration of our recommendations. We greatly appreciate the open process by which NAIC has proceeded to develop its proposal. Please let me know if you have any questions.

Howard Shapiro | Director, Public Policy | Alliance of Community Health Plans
Ph: 202-785-2247 | Fax: 202-785-4060 | Email: hshapiro@achp.org

From: Snyder, David [<mailto:dsnyder@aiadc.org>]
Sent: Sunday, May 30, 2010 8:04 AM
To: Sells, Todd, NAIC
Subject: FW: AIA Comments to Latest Exposure Draft

Dear Todd,

Below are comments submitted by AIA regarding the business to be included, by our request to delete Columns 5 and 7, or by an alternative which we provided regarding Section 6. We wish to reiterate and resubmit the substance of these comments to the NAIC in connection with the latest exposure draft. Could you indicate by return email that you have received this request?

Also, could you indicate what the next steps will be for this initiative?

Thank you and all the best.

Sincerely,

David F. Snyder

From: Snyder, David
Sent: Mon 5/17/2010 1:39 PM
To: 'tsells@naic.org'
Subject: AIA Comments

Dear Todd,

The American Insurance Association wishes to make the following comments on Health Reform Blanks Proposal exposure May12.doc:

We request that Column 5 (Other Business) and Column 7 (Other Health) be deleted from this proposed blank. The purpose of the blank is to facilitate computation of the Medical Loss Ratio under newly enacted Section 2718 of the PHSA. Columns 5 and 7 represent business that is not subject to Section 2718 of the PHSA and should therefore be deleted.

The proposed blanks requires the compilation and categorization of significant data that offers no regulatory value other than for the purpose of standardizing the computation of the medical loss ratio of products subject to Section 2718. We can see no reason that insurers should be expected to divert resources and incur additional expense for the development and reporting of complex data for which there is no regulatory requirement.

The most direct means of targeting the proposed blank to business subject to Section 2718 is through the deletion of columns 5&7. As an alternative, columns 5&7 could be deleted and instructions for Section 6 developed stating:

"Column 6 Other All other health care business not reported in columns 1 through 4 but specified by regulations promulgated by HHS, in consultation with the NAIC, as subject to the medical loss ratio requirement of Section 2718 of the PHSA."

Thank you.

Sincerely,

David F. Snyder,
Vice President and
Associate General Counsel



An independent licensee of the Blue Cross and Blue Shield Association

June 2, 2010

Honorable Wayne Goodwin
Commissioner, North Carolina Department of Insurance
430 North Salisbury Street
Raleigh, NC 27611

By Electronic Mail

Dear Commissioner Goodwin:

As the state's largest health insurer, Blue Cross and Blue Shield of North Carolina (BCBSNC) has a long and distinguished history of helping to lead improvements to North Carolina's health care system. With the health care reform debate in Washington now behind us, we are committed to continuing with that mission – and to working with you and other critical stakeholders to make the new law work for the people of our state.

Many health care reform regulations that will govern our industry are still to be written. As those regulations are developed, on behalf of our 3.7 million customers, BCBSNC feels a responsibility to offer our comments on the issues for which we have expertise.

Specifically, we appreciate your considering BCBSNC's experience as the National Association of Insurance Commissioners works to provide recommendations to the Department of Health and Human Services related to definitions of medical loss ratios (MLRs) in section 2718 of the Public Health Service Act ("PHSA") as added by the Patient Protection and Affordable Care Act ("PPACA").

In consideration of the development of NAIC's MLR recommendations, we strongly believe that expenses related to improving health care quality should be adequately captured under the "quality improvement" component of the final MLR definition. Over the past few decades, BCBSNC and other health plans have demonstrated that such initiatives are critical to any insurer's ability to positively influence the health of its customers. BCBSNC has strived to improve the health overall of as many members as possible rather than focusing narrowly on small populations. We would like to highlight a few of the categories of activities that we believe should be included under "quality improvement", by providing a few examples of how BCBSNC has invested in quality improvement activities that have helped improve health and outcomes for our entire membership:

Provider outreach activities to develop and pilot new ways to improve quality:

- BCBSNC was the first North Carolina insurer to implement Bridges to Excellence (BTE), a program that recognizes and rewards physicians who meet stringent national

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quality of care standards. Data analysis shows that patients of BTE physicians receive fewer high-cost imaging tests and have fewer visits to the emergency room and specialists. As a result, annual health care spending is less per patient than for the BCBSNC customer population as a whole.

BCBSNC would prefer to keep available the option of providing incentives and rewards to physicians and hospitals, such as those used in Bridges to Excellence, in ways other than the traditional fee schedules.

- BCBSNC has also partnered with several primary care practices for an integrated, medical home model of care management collaboration that is being piloted this year. This project seeks to maximize the resources and care coordination efforts of BCBSNC and health care providers. By integrating services of BCBSNC and providers, a member's health care needs can be managed more efficiently and effectively, which will improve quality of care overall. In this effort, BCBSNC care management staff partner directly with physician practice staff and share information and provide assistance to patients that might otherwise require physician office staff resources.

Member health improvement activities:

- **Disease Management:** Our Member Health Partnerships programs offer educational materials and support services, including health coaching, to improve their health and manage specific health conditions, such as asthma, diabetes, tobacco cessation, weight management and more. These disease management programs provide direct benefits to BCBSNC members.
- **Nurse Line and Health Education:** Health Line Blue is the BCBSNC 24-hour-a-day/seven-days-a-week information resource that provides members with symptom support management, education, treatment decision support and chronic condition management by nurses, dietitians and respiratory therapists. Health Line Blue focuses on member education and encourages shared decision-making.

Patient safety activities:

- In 2006, BCBSNC joined forces with more than 100 North Carolina hospitals to help them reach their goal of becoming the safest hospitals in the nation. The purpose of the partnership is to reduce medical errors that result in costly complications and, in some cases, even death. BCBSNC is providing resources to enhance the efforts of these hospitals to implement nationally recognized quality improvement measures. North Carolina is taking a leadership role in implementing cutting-edge patient safety initiatives, as well as a collective push to improve overall quality of care. The result will be a win-win not only for the hospitals and their patients, but also for the state of North Carolina.

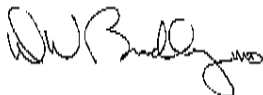
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It is important that activities such as those mentioned above are included in the quality improvement category of the MLR definition to ensure appropriate resources are available. BCBSNC customers and all other Americans deserve the right to maintain access to valuable programs that are targeting health improvement.

Regarding MLR reporting and rebate deadlines, we believe MLR reports should be filed annually and made due no earlier than June 30, with rebates paid by August 31. This will allow time after the end of the calendar year for claims to be submitted and paid, and thereby reduce the estimation needed to determine which claims were incurred but are still outstanding. After reports are filed, sufficient time is needed to identify which enrollees are due rebates and in what amounts. By way of example, Medicare Supplement loss ratio refunds are paid one month later – by September 30.

Thank you for your consideration of our comments on MLR requirements under PPACA and NAIC's work on this issue. Sustainable health care reform can only be successful if health insurers and health care providers collaborate and engage consumers. We're committed to doing our part. Please let me know if you have any question regarding these comments, the programs mentioned here or other quality initiatives.

Sincerely,



Don W. Bradley, M.D.
Senior Vice President, Chief Medical Director
Blue Cross and Blue Shield of North Carolina

cc: Mr. Lou Felice, Chair, Health Care Reform Solvency Impact Subgroup, National Association of Insurance Commissioners and Mr. Steve Ostlund, Chair, Accident and Health Working Group, National Association of Insurance Commissioners

June 2, 2010

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

Mr. Steven Ostlund
Chair, Accident and Health Working Group, NAIC

Re: Medical Loss Ratios - Special Circumstances for Smaller Health Plans -
Via Email

Dear Messrs. Felice and Ostlund:

As a smaller health plan, we are writing to provide our unique perspective on the reporting requirements and calculation of the Minimum Loss Ratio (MLR) discussed in Section 2718 of the Patient Protection and Affordable Care Act (PPACA). Specifically, Section 2718 (c) requires the NAIC to consider the special circumstances of smaller plans, different types of plans, and newer plans when developing its methodologies. In addition, we believe that the PPACA was intended to promote and maintain competition in the health insurance industry, and smaller companies, such as ours, can play a key role to that end if it is properly implemented.

Reinsurance

As correctly noted by the NAIC in their May 12th response to Health and Human Services concerning the calculation of the MLR, smaller blocks of business are subject to significant variations in their experience, especially if there are large claims. As a result, smaller plans rely on reinsurance partners to assist with absorbing this risk. In contrast, larger plans generally have the capital and membership base to absorb higher levels of adverse claims experience. Thus, they tend to reinsure a smaller percentage of the premium volume.

Reinsurers also provide a host of valuable ancillary services as part of the reinsurance arrangement. Smaller carriers tend to utilize these services more than their larger counterparts. Examples include: assistance with pricing, general market information, such as, claims trends, assistance with compliance questions, etc.

Reinsurers charge premiums for these services, usually on an excess loss or quota share basis, which include their own administration expense and profit requirements. Generally, the expense and profit requirements decrease as a percentage of the premium as the size of the reinsured block increases; however, they are largely unknown and outside the control of the smaller carrier.

Regarding 2718, reinsurers are *not* obligated by Section 2718 to achieve an MLR or pay rebates; however, their expenses and profit charges *must* be included in the premium that is charged to the group or individual. Although smaller carriers do bid and compare reinsurers' rates for reasonability, the premiums are largely dictated by the reinsurer, the reinsurance market, and the need for a smaller company to have a long-term relationship with a good reinsurance partner.

Recommendation

We recommend that the premium in the denominator be adjusted to consider the impact of reinsurance. Specifically, we recommend removing the portion of the premium (after expense allowance) ceded to the reinsurer and including claims recovered from the reinsurer.

As an alternative, the claims in the numerator could be adjusted by removing the claims ceded to the reinsurer and adding, in its place, the premium (before expense allowance) ceded to the reinsurer. The premium in the denominator should already reflect any expense allowance, thus no adjustment is necessary.

These approaches recognize the crucial role of reinsurance to a smaller plan by addressing the expense of transferring the risk to a reinsurer. Both methods would also reduce a smaller carrier's potential MLR volatility.

PPACA Compliance and Taxes

Complying with the various requirements of the PPACA will require additional resources in terms of information technology and human resources. These additional resource requirements for a smaller plan are significant when compared to a larger plan. For Example, BEST Life currently has approximately 40 full time employees. Adding one person, particularly in IT, Finance, or Actuarial, can have a large impact on the expense ratio when compared to a larger company.

Recommendation

We recommend that expenses attributed complying with the PHSA be removed from the denominator in the MLR calculation.

In addition, we recommend that *all* taxes (e.g., property, Social Security, etc.) be removed from the denominator as smaller carriers typically operate on smaller profit margins before taxes and Federal and State taxation is completely outside the control of a smaller carrier. An increase in the level of taxation could potentially cause a smaller carrier to leave a state or the market entirely because they would not be able to meet the 80% MLR requirement and earn a reasonable profit due to a tax increase.

Commissions and Other Acquisition Expense

Smaller carriers often lack the brand recognition of larger carriers. Thus, in order to attain membership and compete, they typically market in rural areas underserved by larger carriers (due to a lack of volume) and pay higher commissions than larger carriers. These areas tend to be serviced by a few independent agents who are compensated entirely on commissions paid by the carrier.

In the future, smaller carriers will have to allocate a larger portion of the expense budgets toward developing their brands in order to prepare for 2014 and competing on an exchange.

Recommendation

We recommend that a portion of a small carrier's acquisition cost be removed from the denominator in the MLR calculation. This is to help the smaller carriers build their membership base and brands in order to compete in the exchange environment.

Loss Adjustment Expense (LAE)

We would like to reiterate several points made by other carriers in their comments regarding the issue of whether to include LAE as permissible expenses:

- Permitting them is consistent with the NAIC's current definition for claims and claims adjustment expense (SAP 85),
- Permitting them is consistent with the requirements of Section 2718 (a), and
- Not permitting them favors staff model HMOs over PPO plans.

Recommendation

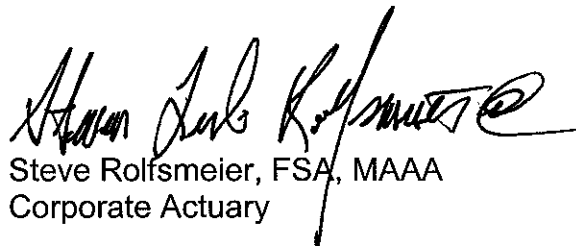
We recommend adopting the NAIC's definition for claims and claims adjustment expense (SAP 85).

Although the above recommendations are by no means exhaustive, we do believe they are key considerations for many small health plans such as ours, and, if implemented, will help ensure smaller health plans', both existing and start-ups, contributions to a competitive marketplace.

Sincerely,



Don Lawrenz
President



Steve Rolfsmeier, FSA, MAAA
Corporate Actuary

Cc: Todd Sells
Director, Financial Regulatory Services
tsells@naic.org

John Englehart
Chief Managing Actuary, Life/Health
jengelha@NAIC.org

Secretary Kathleen Sebelius,
The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 201201

Subject: FW: Comment on Proposed Supplemental Health Care Exhibit

June 1, 2010

Dear Mr. Felice and Mr. Sells:

Thank you for the opportunity to comment on the proposed reporting forms. In reviewing the General Instructions of the 5/20 draft, we noted the statement that "The allocation of premium between jurisdictions should be based upon situs of the contract" and also the statement "For individual business sold through an association, the situs of the contract shall be based on the issue state of the certificate of coverage".

National Health Insurance Company is a carrier that writes individual market coverage both through individual policies and through association group policies. Our premiums and claims records for annual statement and premium tax reporting are maintained based on the resident state of the insured, which often is different than the original contract state of the individual policy or certificate. We would not be able to administer a separate set of records just for the purpose of this new reporting.

We would suggest that reporting on either the basis of the resident state or the situs state should be acceptable for individual market coverage. Your consideration of our comments in this matter is very much appreciated.

Sincerely,

Eva A. Green
Vice-President, Compliance
National Health Insurance Company
800-237-1900, x3410
eva.green@nhic.com

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