



April 27, 2010

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

Re: Medical Loss Ratio of Section 2718 of the Public Health Service Act

Dear Mr. Ostlund:

On behalf of the 39 independent members of the Blue Cross Blue Shield Association, who collectively provide health insurance benefits to almost 100 million Americans, we appreciate the opportunity to provide comments to the Accident & Health Working Group and its subgroups regarding §2718 of the Public Health Service Act (PHSA) added by the Patient Protection and Affordable Care Act (PPACA). Our comments relate to both the health insurance products that should be subject to §2718 as well as the data elements used in the ratios described.

### **Products Subject to § 2718**

We would like to clarify which health insurance products are subject to §2718. From the NAIC Health Reform Solvency Impact Subgroup call on April 21, 2010, it appears that the regulators believe that all business reported in the comprehensive major medical category within the NAIC Annual Statement is subject to §2718.

In addition, we believe that under PPACA and the PHSA definitions, the Federal Employees Health Benefit Program (FEHBP), which is a fully-insured large employer comprehensive major medical program, would also be subject to §2718. The segregated reporting of FEHBP from other comprehensive major medical business within the NAIC Annual Statement was prompted by its exemption from state premium taxes and not due to being considered non-comprehensive.

Specifically, under the PHSA, health insurance coverage means “benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.” 42 U.S.C. §300gg-91(b)(1). Group health insurance coverage is defined as health insurance coverage offered in connection with a group health plan. 42 USC § 300gg-91(b)(4). A group health plan means “an employee welfare benefit plan (as defined in section 3(1) of [ERISA]) to the extent that the plan provides medical care ... to employees or their dependents ... directly or through insurance, reimbursement, or otherwise.” 42 U.S.C. §300gg-91(a)(1). In other words, the PHSA applies to group employee welfare benefit plans, as defined in ERISA section 3(1), which are offered by an insurance company where the plan is providing medical care to the group’s employees or their dependents. Thus, FEHBP coverage provided by a health insurance company is group health insurance coverage within the meaning of the PHSA’s definitions.

### **Data Elements Included in §2718**

There appear to be different potential interpretations of §2718 that regulators might reasonably consider in issuing guidance on the medical loss ratio requirements. Specifically, one issue we have been examining

involves the treatment of loss adjustment expenses under the first sentence of §2718(a) and how it relates to the ratios described under §2718(a) and (b).

The introductory sentence to subsection (a) reads (with extraneous words removed), “A health insurance issuer ... shall ... submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums.” The next sentence, which seems to be further clarify the information to be reported, states: “Such report shall include the percentage of total premium revenue ... that such coverage expends –

- (1) On reimbursement for clinical services provided ...
- (2) For activities that improve health care quality; and
- (3) On 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. ”

The question is whether it is reasonable to interpret this provision to require each health insurer to submit a report detailing paragraphs (1) through (3) that incorporate incurred claims, loss adjustment expenses, change in contract reserves (if applicable to the business), and earned premiums as outlined in the first sentence of subsection (a). In other words, paragraphs (1) and (2) would include the components of the ratio described in the first sentence of §2718(a), and paragraph (3) would include “all other non-claims costs” (along with the explanation of those costs). Since paragraph (3) refers to “all other non-claim costs,” claims costs such as loss adjustment expenses logically must fall under paragraph (1). It should be noted that the NAIC Accounting Practices and Procedures Manual defines both “loss adjustment expenses” and “claim adjustment expenses” to be the costs in connection with the adjustment and recording of claims.

Under this interpretation, the expenditures for the reimbursement for clinical services, subsection (a)(1), would include the actual incurred costs for clinical services, the associated costs for reimbursement (loss adjustment), and the change in contract reserves, if any (given that contract reserves fund future clinical services).

The expenditures for activities that improve health care quality, paragraph (2), include costs associated with healthcare quality improvements (yet to be specified), which is a subset of loss adjustment expenses as currently defined by the NAIC. Since the healthcare quality improvement costs are specifically identified in paragraph (2), they need to be excluded from the loss adjustment expenses in paragraph (1).

The other non-claims expenditures, paragraph (3), would include general administration expenses and commissions, but exclude Federal and State taxes and licensing or regulatory fees. Under this interpretation:

Ratio (a)(1) equals:  $\{incurred\ claims + (loss\ adjustment\ expenses - healthcare\ quality\ expenses) + change\ in\ contract\ reserves\} / \{earned\ premiums\}$

Ratio (a)(2) equals:  $\{healthcare\ quality\ expenses\} / \{earned\ premiums\}$ , and

Ratio (a)(3) equals:  $\{general\ administrative\ expenses + commissions - Federal/State\ taxes\ \&\ fees\} / \{earned\ premiums\}$

The rebate provision set forth in §2718(b) relies on the costs reported within the ratios under subsection (a)(1) and (2) for its purposes. While subsection (a) outlines an insurer’s total expenditures for public reporting and posting, subsection (b) outlines the reporting for the minimum loss ratios and any resulting rebates. Subsection (b)(1)(A) defines the ratio as “the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue

(excluding Federal and State taxes and licensing or regulatory fees ...).” This reduction for taxes and fees in subsection (b), which is apparently not provided for in §2718(a), results in a ratio under §2718(b) which will differ from the sum of the ratios in subsection (a)(1) and (2).<sup>1</sup>

Therefore, the subsection (b)(1)(A) ratio equals:  $\{incurred\ claims + loss\ adjustment\ expenses\ (includes\ healthcare\ quality\ improvement\ expenses) + change\ in\ contract\ reserves\} / \{earned\ premiums - Federal/State\ taxes\ \&\ fees\}$

In support of this interpretation of §2718, we note that the questions in the Request for Comments Regarding Section 2718 of the Public Health Service Act prepared by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (RFI) seem to support the inclusion of LAE in the ratios. The second paragraph of page 7 reads, “Specifically, Section 2718(a) of the PHS Act requires health insurance issuers offering group or individual coverage to submit a report to the Secretary for each plan year, concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums (also known as the medical loss ratio (MLR)).”

This interpretation also seems consistent with the concept of comparing the medical loss ratios across insurers. Capitation payments to providers for clinical services inherently include some loss adjustment expenses. Insurers utilizing capitation arrangements would include the full capitation payment (the amount for clinical services and the amount for loss adjustment) in their incurred claims amounts. For staff model HMOs, the expenditures for doctor and nurse salaries plus owned-facility operating costs, which cover both medical and administrative costs, would be included in their incurred claims amounts. Therefore, the ratios produced under the interpretation outlined above would be comparable across various insurers. We note that §2718’s exclusion of federal and state taxes and fees from the ratios evidences an analogous intent to ensure comparable ratios across different insurers given that insurers have varying tax obligations based on their licensures, non-profit status, state laws, and other factors.

We certainly appreciate that the language of the law is not entirely clear and that other reasonable interpretations may exist, while the time line to reach conclusions and develop the recommendations is very brief. Nevertheless, we believe these are important issues that your group may want to consider. We are happy to discuss these comments with you further during the upcoming conference calls. Please feel free contact me directly at 312.297.6093 if I can be of assistance.

Sincerely yours,



Shari Westerfield, FSA, MAAA  
Actuarial Services

cc: Lou Felice, Chair, Health Reform Solvency Impact Subgroup  
Richard Diamond, Chair, Actuarial MLR Subgroup  
John Engelhardt, NAIC Staff

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<sup>1</sup> It seems possible that the failure to reduce the premiums by Federal and state taxes and fees for purposes of the denominator of the ratios in §2718(a) may have been an oversight. We note that for purposes of §2718(a)(3), these amounts were excluded. Thus, reducing premiums by these amounts would arguably have produced more complete and meaningful ratios, which would have been consistent with the determination of the MLR in §2718(b).