

May 17, 2010

Lou Felice  
Chair, Health Care Reform Solvency Impact Subgroup  
National Association of Insurance Commissioners

**Re: Supplemental Health Care Exhibit**

Dear Mr. Felice:

Health Care Service Corporation (HCSC) is the nation's largest customer-owned health insurer and the fourth largest health insurer overall, with 12.4 million members in our Blue Cross and Blue Shield plans in Illinois, New Mexico, Oklahoma and Texas. We appreciate this opportunity to provide comments to the NAIC on the May 12, 2010 exposure draft of the new Supplemental Health Care Exhibit (hereafter, Exhibit).

In addition to creating a new financial reporting requirement for health insurers, the exposed Exhibit encapsulates the NAIC's current thinking on appropriate medical loss ratio (MLR) definitions applicable to the new federal rebate requirements, added to §2718 of the Public Health Service Act via the recent passage of the Patient Protection and Affordable Care Act (PPACA). As such, we have organized our comments into three sections: policy comments relating to the MLR definition used in the Exhibit; policy comments relating to the nature and purpose of the proposed Exhibit; and technical comments regarding the Exhibit's structure and instructions.

*Policy Comments on MLR Definition*

The Exhibit's MLR calculation involves a numerator consisting of items currently reported as incurred claims in NAIC financial reporting, together with a small set of expenses falling into a newly-defined category of "improving health care quality" expenses. We believe this approach to defining the MLR used for §2718 rebate purposes is unnecessarily narrow and could have unintended consequences. Attached as an appendix to this letter is an excerpt from comments sent by HCSC last week to the federal government, in response to the government's Request for Comments on §2718. In those comments, we argued that both cost containment expenses and other claims adjustment expenses should be included in the numerator of the federal rebate MLR definition, in order to produce a metric that is not only comparable across all different types of health insurers, but also reflective of insurers' efforts to provide their members with affordable and quality healthcare.

As such, we encourage the NAIC to expand the MLR definition in the Exhibit to include not just the new concept of "improving health care quality" expense, but all claims adjustment expenses.

In the event that the NAIC continues down its current path, however, we recommend that the following changes be made to the definition of “improving health care quality” expenses:

1. *Fraud prevention costs should be included in the definition.* An insurer’s fraud prevention activities are not only an important contributor to keeping health insurance affordable; they also promote quality healthcare, by creating disincentives for certain providers to administer unnecessary and potential harmful care as part of insurance fraud schemes.
2. *Utilization review costs should be included in the definition.* These activities promote affordability of health insurance, but at the same time they also promote healthcare quality by helping ensure that the care provided to enrollees is truly necessary and efficient.
3. *Disease management and wellness programs that apply to broad populations, and not just individually tailored programs, should be included in the definition.* It is unclear what purpose is served by the tentative definition’s focus on “hands on” programs to the exclusion of population-wide programs. Programs whose impact on quality can be “objectively measured and verified” merit inclusion in the definition, regardless of whether they are individual or population-wide in nature.
4. *The definition should specify safe harbor expense categories but should not stifle insurer innovation.* Insurer innovation in health care quality initiatives should be encouraged, and the approach taken in the definition—wherein items not specifically listed cannot be included until HHS/NAIC has determined that they are allowable—could stifle that innovation.
5. *Programs aimed at improving the health care of the general population should be included in the definition.* Like many not-for-profit health insurers, HCSC devotes resources to improving the health care of the communities we serve by offering free immunizations and health screenings, and by making direct grants to hundreds of community organizations conducting health improvement and education programs. Failure to include these expenses in the definition of “improving health care quality” expenses would discourage health insurers from engaging in these activities.

#### Policy Comments on Exhibit

As we understand it, the Exhibit was designed to serve the needs of state insurance regulators only, and was not intended to also be the reporting mechanism by which insurers would submit MLR information to federal regulators as required by §2718. From this standpoint, we offer the following comments relating to the function and purpose of the Exhibit:

- *Insurers should not be required to submit the Exhibit as part of year-end 2010 financial reporting.* In light of PPACA §1004(a), federal MLR reporting requirements under §2718 only apply for plan years starting after September 23, 2010. As such, the policy

rationale for asking insurers to report calendar year 2010 information using the §2718 MLR definition is not clear, since such reporting would primarily relate to plan years starting prior to September 23, 2010. Furthermore, HCSC and other health insurers will need to undertake significant changes to administrative processes in order to comply with §2718 and prepare reports under the new MLR definition; requiring that these changes be accelerated to year-end 2010 financial reporting is unnecessarily burdensome.

- *Insurers should not be required to submit the Exhibit on a quarterly basis.* Health insurance products, particularly those most popular in the individual and small group markets, exhibit strong seasonality of medical loss ratios during a calendar year. If insurers are required to file the Exhibit on a quarterly basis, then we believe it will be very common to see MLRs reported in early quarters of the year that lie below the federal MLR thresholds, even though the MLRs reported for the full year lie above those thresholds. This situation would cause considerable confusion to consumers, as the information from quarterly filings may create erroneous expectations about the likelihood of future rebates. Consequently, it is unclear to us what value would be provided by having insurers report this information less frequently than annually.
- *The Exhibit should not be reconciled to and submitted alongside the Annual Statement, but should instead be submitted later in the year.* It seems likely that the annual MLR calculation for federal rebate purposes will not be calculated using values consistent with an insurer's year-end general ledger (which include material estimates for unpaid claims), but instead will be calculated at a later time in the year (so as to allow for claims runout). Consequently, the MLR values that an insurer ultimately reports to federal regulators for a given year will likely vary from values calculated for the same year based on that year's Annual Statement information. This observation calls into the question the value of asking insurers, via this Exhibit as currently constructed, to calculate the federal MLR using Annual Statement information. The existence of two different MLR values purporting to be the same thing—one from state reporting tied to the Annual Statement, and one from later federal reporting reflecting claims runout—may cause confusion.

### Technical Comments

We recognize that the NAIC has needed to act swiftly in developing the proposed Exhibit and exposing it for comment, given the federal government's stated desire to receive the NAIC's recommendations on §2718 definitions by June 1, 2010. Nevertheless, the Exhibit as exposed appears to need further technical refinement in a number of areas. We would ask that you consider making the following technical changes to the Exhibit and its instructions:

- *Clarify how "small group" and "large group" are to be defined.* PPACA §1304(b) indicates that, for federal purposes, "small group" includes groups with up to 100 employees, except in states exercising an option under PPACA §1304(b)(3) to define small group as groups up to 50 employees until 2016. In light of this, it seems likely that any federal MLR reporting under §2718 pertaining to the small group market will, at least for states not exercising the §1304(b)(3) option, represent a different definition of

small group than the definition used in current NAIC financial reporting. In this light, we believe it would be helpful for the Exhibit's instructions to indicate how small group is to be defined for purposes of the Exhibit.

Note that if the NAIC decides to use existing state definitions of small group in the Exhibit, then the MLR calculations shown in the exhibit could diverge materially from those relevant to federal reporting, which would exacerbate concerns expressed above about the value of the Exhibit. On the other hand, if the NAIC decides instead to use the PPACA definition of small group, that would exacerbate concerns expressed above about the ability of HCSC and other insurers to prepare the Exhibit for year-end 2010 financial reporting. The best course of action may be to use the federal definition of small group but defer the Exhibit until year-end 2011 reporting.

- *Clarify that the allocation of claims by state should be consistent with the allocation of premiums by state.* This seems like an obvious objective. However, the first sentence of the Exhibit instructions could be interpreted as saying that claims are to be allocated based on the state in which healthcare services are provided, whereas the second sentence is clear that premiums are (appropriately, in our view) to be allocated based on situs of the contract.
- *Clarify the relationship between Part 1 and Part 2.* It seems likely that Part 1 Line 1.1 was intended to be the same as Part 2 Line 1.8, and that Part 1 Line 2.1 was intended to be the same as Part 2 Line 2.10. If so, the instructions should be rewritten in order to clarify that intent. Also, conforming changes to the Exhibit may be necessary in order to reflect that intent. For example, incurred medical incentive pools and bonuses are included in Part 2 Line 2.8 and hence in Part 2 Line 2.10; as such, if Part 1 Line 2.1 is equal to Part 2 Line 2.10, then Part 1 Line 3 should be deleted to avoid double-counting.
- *Clarify the instructions to Part 1 Line 1.5.* The current instructions for this line read: "Include federal income taxes allocated to premium and not related to other aspects of a company's operations (e.g., taxes on investment income and capital gains)." We assume that the intent is not for income taxes to be allocated by premiums per se, as allocating by underwriting gain seems more appropriate. We suggest changing this wording to: "Include all federal taxes and assessments allocated to health insurance coverage reported under §2718 of the Public Health Service Act."
- *Move information on prescription drug claims and pharmaceutical rebates from Part 1 to Part 2.* We see no reason why prescription drug claims and pharmaceutical rebates should be separately presented in Part 1 Lines 2.2 and 2.3. These items should be incorporated into Part 2, and included in the definition of "Total Incurred Claims" that flows from Part 2 to Part 1 Line 2.1.
- *Clarify which portions of Part 1 should not be filled in.* We recommend that "XXX" be placed in the following portions of Part 1, making it clear that these fields are not to be filled in:

- *Lines 11.1 through 11.3, Columns 1 through 6.* HCSC currently reports all activities relating to SSAP 47 uninsured plans in the “Other Health” column of the Annual Statement. As such, we anticipate that all of the information relating to Lines 11.1 through 11.3 should be reported in Column 7.
- *Lines 12 through 14, Columns 1 through 7.* Health insurers are not currently required to, and in our experience typically do not, allocate investment income (Line 12) by product. Federal income taxes that do not merit inclusion in Line 1.5 (Line 13) are not currently being, and should not need to be, allocated by product. Given these observations, an allocation by product of net gain (Line 14) is not meaningful.
- *All “Other Indicators” Lines, Columns 6 through 7.* These metrics will typically not be meaningful for products not included in Columns 1 through 5.
- *Modify the definition of Part 1 Line 10.* In order to produce an underwriting gain metric consistent with the current NAIC definition of that term, several changes to the stated formula appear to be required: replacing Line 1.9 with Line 1.12 less the portion of Line 1.5 representing federal income taxes rather than federal assessments; replacing Line 4.0 with Line 4.4; and including Line 11.3.
- *Delete Part 3.* The format of this exhibit is quite confusing (with considerable overlap between the row headings and the column headings); the administrative burden involved for health insurers to report expenses at this level of granularity is significant; and the regulatory value of requiring this level of granularity about “improving health care quality” expenses is not clear.

Thank for your consideration of these comments.

Sincerely yours,

Maurice S. Smith  
Vice President, HCSC Reporting

## Appendix

*The following paragraphs are excerpted from comments filed by HCSC on May 14, 2010 with the Departments of Health & Human Services, Labor, and Treasury in response to the Federal Register's April 14, 2010 Request for Comments on §2718.*

The first sentence of §2718(a) creates a requirement for issuers to report on its ratio of claims, loss adjustment expenses (LAE), and change in contract reserves to premiums. The remainder of §2718(a) then creates other related reporting requirements for issuers, while §2718(b) uses those reporting requirements to define the MLR relevant for rebate calculation purposes. In our view, the statutory language is unclear, resulting in differing interpretations as to the categories of insurer expenditures to be included in the numerator of the MLR used in the rebate calculation.

HCSC believes that a fair and appropriate interpretation of the statutory language is that the numerator of the MLR used in the rebate calculation should include all amounts that an insurer currently reports as claims or as loss adjustment expenses in the financial reporting to insurance regulators under standards promulgated by the National Association of Insurance Commissioners (NAIC).

NAIC accounting guidance, in Statement of Statutory Accounting Principles (SSAP) 85, divides a health insurance issuer's loss adjustment expenses (LAE) into two main categories: Cost containment expenses (CCE), and non-CCE LAE. Both of these categories of expenses provide value to consumers:

- CCE activities include case management, fraud prevention programs, and provider network development. These activities clearly serve to keep costs, and consequently premiums, lower than they would be if issuers did not perform these activities. As such, these insurer expenditures provide value to consumers in terms of lower premium rates, and, therefore, should not be discouraged by regulators.
- Non-CCE LAE activities include the adjudication of enrollees' healthcare benefits, which are a necessary component of the enrollees' ability to receive value for the premiums they pay. Moreover, it is important to note that these activities provide value to consumers above and beyond the payment of claims. Adjudication of benefits is the means by which consumers receive the benefit of negotiated prices between issuers and providers for all healthcare services, even those that may not result in insurance claims payment, such as enrollee cost-sharing features like deductibles or no-balance-billing requirements in provider contracts.

HCSC believes there are three primary reasons why including both CCE and non-CCE LAE within the numerator of the MLR is appropriate policy for §2718 rebate purposes:

1. *Appropriate measurement of value.* The stated purpose of the rebate provisions, quoting the title of §2718(b), is "ensuring that consumers receive value for their premium payments." As discussed above, both CCE and non-CCE LAE activities provide significant value to consumers in reduced premiums and reduced out-of-pocket costs.

2. *Fairness across companies.* If CCE and non-CCE LAE are not included in the numerator, then certain types of health insurance companies may derive unfair competitive advantage in the calculation of rebates. Companies that use their own employees and facilities to directly deliver care, companies that transfer risk to providers via capitations, and companies that outsource certain activities rather than perform them internally may be able to classify certain expenditures as claims expense and, therefore, included in the numerator; whereas when other companies perform these same functions, their corresponding expenditures could be classified as a mixture of claims, CCE, and non-CCE LAE. Inclusion of CCE and non-CCE LAE in an MLR numerator is necessary to create a metric that can be applied consistently across the entire industry and thereby ensure a level playing field across all different types of health insurance issuers.
3. *Supporting appropriate insurer behavior.* By including CCE and non-CCE LAE in the numerator, health insurers would be motivated to devote resources to those activities, which would then constrain future growth in premium rates, consistent with the desire for health insurers to play a leading role in helping to “bend the cost curve” and achieving the affordability objectives of PPACA.

For these reasons, we urge HHS to:

- include both CCE and non-CCE LAE in the numerator of the MLR for rebate calculation purposes
- monitor emerging experience over the first two to three years that §2718 requirements are in effect
- based on this experience, determine whether changes to the rebate MLR thresholds may be warranted.

This approach would allow a careful consideration of whether or not the policy objectives of §2718(b) are being met, without the potential market disruptions that could occur if the rebate MLR numerator is defined in a way that creates an unlevel playing field between different types of health insurance issuers.