

May 13, 2010

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Mr. Lou Felice
Chair, Health Reform Solvency Impact (E) Subgroup
C/O New York Department of Insurance
25 Beaver Street
New York, New York 1004-2319

RE: Expenses and Medical Loss Ratios under Federal Health Care Reform

Dear Commissioner Morrison and Mr. Felice:

We write on behalf of Rocky Mountain Health Plans (RMHP) and Colorado Choice Health Plans (SLV HMO) to provide input and comments on definitions and a standardized methodology for calculating medical loss ratios pursuant to sections 1001 and 10101 of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (PPACA), (Pub. L. 111-148) (referenced hereafter as PPACA Section 2718).

Our companies are Colorado-based non-profit health plans that offer coverage to individuals and groups in our state. We provide coverage for our members with a strong emphasis on care coordination and quality.

The successful results of RMHP's efforts to contain costs through quality of care and collaboration have been recognized publicly in several forums, including the Dartmouth Atlas report, and Grand Junction, Colorado: A Health Community that Works, L. Nichols, New America Foundation (2009). Most recently, RMHP received a Beacon Community Grant which will allow us in collaboration with our partners, Quality Health Network, Inc.; St. Mary's Hospital; and Mesa County Physicians Independent Practice Association to enhance health information exchange and quality improvement results in a seven county area.

Colorado Choice and SLVHMO serve only rural communities that all have limited health care resources and physician shortages. Collaborations between the community, local providers and SLVHMO are focused on improving quality of care for residents of these rural counties. Quality improvement and cost containment initiatives, such as the adult and pediatric chronic care management programs and the health risk assessment program coupled with health and wellness education offered through SLVHMO have created a service not readily available elsewhere in these areas. The ability to include these programs in the MLR is critical to their sustainability.

Both companies have a long-standing mission to improve the health of our members. As state-based, non-profit organizations with a strong care coordination and quality focus, it is important that the new MLR and rebate requirements are implemented in a way that allows us to continue our mission.

PPACA Section 2718 tasks the NAIC with developing uniform definitions of the activities reported under 2718(a), as well as the standardized methodologies for calculating “measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2) (of Section 2718).”

State based analysis.

A critically important issue is the level at which the premium and medical cost information will be collected and analyzed. There is a debate on whether or not this should be at a national level or at a State level. We believe that the best way to ensure that the public receives meaningful and useable information is to calculate for each company a state-wide loss ratio for the small group and individual market segments. This provides a more level playing field for local state based carriers. This approach recognizes that health care is a local or regional activity. Companies conduct business on a state basis and premiums are primarily driven by provider cost and charges and utilization patterns in a local or state geographical area. Moreover, the Exchanges contemplated by PPACA will function on a state or regional basis.

MLR - Credibility and Averaging

We recommend that the MLR calculation include credibility adjustments following a methodology similar to the NAIC Annual Medicare Supplement Refund Calculation. If a credibility adjustment is not included in the MLR calculation, it will result in unstable premium rates due to the claims volatility prevalent in smaller lines of business. Also, the potential of providing rebates one year, but absorbing losses the next, could force local non-profit carriers to face solvency challenges which would result in fewer choices for consumers and less competition. This issue is of particular concern to local non-profit carriers where access to capital is limited to organic growth. Therefore we also support a rebate calculation that smoothes experience by averaging the MLR's over time.

Quality Improvement, Cost Containment and Community Benefit Expenses

Costs incurred to improve the health of our members and to deliver care efficiently result in decreased medical costs. It is critical that the medical loss ratio not be used in a manner that penalizes plans for providing cost containment programs or quality activities. If such costs, including the overhead that supports such programs, are not clearly defined as activities that improve health care quality, the unintended result would be a disincentive for companies to create, continue or participate in such quality programs which benefit consumers. To the extent that the regulatory system for PPACA section 2718 sets up a paradigm under which carriers are penalized for providing these high quality services to their enrollees and

beneficiaries, we believe the goals of the legislation will not be met. As such, we strongly recommend that all cost-containment activities, as reported on the NAIC annual statement (Underwriting and Investment Exhibit, Part 3, Column 1, Line 31), be included as medical costs in the MLR calculation.

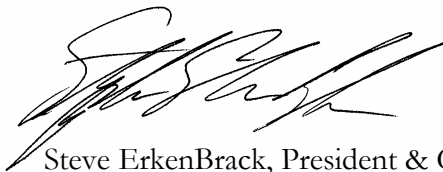
As non-profit plans, we are also concerned that excluding community benefit from the definition of quality activities will have a disproportionate and unfair impact on non-profit health insurers. As you are aware, non-profit health plans are expected to provide direct benefit to the community. Therefore, as a non-profit, our companies expend funds directly on community benefit. For example, RMHP provided start-up funding for Quality Health Network, a health information exchange. PPACA deducts taxes from the premium calculation for the MLR, recognizing that they are not discretionary expenses and should not be included. Likewise, community benefit expenses should not be included. If community benefit expenses are treated as administrative expenses under the MLR regulations, non-profit health insurers are extremely disadvantaged relative to our for-profit competitors.

Premium Revenue

In a typical insurance environment, patient copayments and deductibles are made directly by the patient to health care providers, who keep that revenue. As such, other health insurance issuers' provider costs do not reflect these revenues. RMHP, however, collects and retains these revenues for certain enrollees. To reflect accurately the revenue collected from our enrollees and create a fair comparison to other carriers, the definition of premium revenue should include the enrollees' share of payment that is retained by the plan.

We thank you for considering our comments. If you or your staff has any questions, please feel free to contact us.

Respectfully,



Steve ErkenBrack, President & CEO
Rocky Mountain Health Plans



Cindy Palmer, CEO
Colorado Choice Health Plans
d/b/a SLV HMO