



May 20, 2010

Mr. Steve Ostlund
Chair, Accident & Health Working Group

RE: Preliminary Issue Identification Memo for PPACA Subgroup

Dear Steve:

I write today on behalf of America's Health Insurance Plans (AHIP) to provide the PPACA Subgroup of the Accident & Health Working Group with input and comments on your Preliminary Issue Identification draft distributed on Friday, May 14, 2010. We appreciate, given the short time frames, your willingness to share these preliminary comments. Our comments below are similar to the comments I made on your Subgroup's call on Monday, May 17, 2010. AHIP is the nation's trade association representing nearly 1,300 member companies providing health, long-term care, dental, disability and supplemental coverages to more than 200 million Americans. We appreciate the opportunity to provide comments on this important project. AHIP is committed to the development and maintenance of a strong regulatory regime to oversee United States insurers, particularly those in the health sector.

We have in general recommended a state-based approach to aggregation under which a loss ratio would be calculated for each insurance holding company group in each of the three market segments, with the particular challenges of large employers taken into account.¹ Since later portions of the document note that you are "exploring other options...such as interstate pooling" we wish to suggest that the proposed definitions be flexible in dealing with aggregation. We wish to highlight the following portion of our initial comments to the NAIC:

A flexible process for aggregation should be developed to (i) insure that the credibility standard is reached as quickly as possible for all policyholders so that valid rebates are paid and not deferred, (ii) reduce the potential for paying rebates based solely on statistical fluctuations in year-by-year experience, (iii) allow the use of appropriate risk management within carriers and companies so that risk margins do not need to be increased to reflect greater solvency risk from excessive rebates over a number of years and (iv) allow carriers and companies to coordinate the development of premiums and reasonable premium increases based on their

¹ We note that the draft does not address the determination of "state." The exposed Supplement uses "situs of contract" which we believe is the correct basis for determination. The AHWG may wish to either note that they are not addressing this issue as outside their charge or that they support the Supplement instructions.

accumulating experience in a manner as close as possible to the experience reported for section 2718 reporting.

Such flexibility should be premised on the increased credibility of the results and the consistency of the rating when several states are being pooled. The regulations should spell out the manner in which such multi-state pooling would be subject to change over time. This is critical in that rebate calculations starting in 2014 will be based on loss ratios over a three year period. We stand ready to assist in any such development.

We appreciate the willingness of your subgroup to address the issue of large claims as part of a pooling mechanism. We are concerned that an approach that applies only within a legal entity is too narrow. Subject to sufficient regulatory control, the proposed pooling could be expanded to include stop-loss reinsurance or pooling with affiliates - properly structured with a similar specified maximum amount that must remain within each of the state-individual/small group/large group segments for reporting purposes.

Given that your group has not addressed QI issues, we will not deal with those in this response.

We agree that the reporting of rebates in financial statements must be done in a manner that allows regulators to assess both the amounts of rebates paid for prior periods, the adequacy of any liability established for potential rebates for the current year and the impact of rebates on the solvency of the company. Rebates paid for prior years within the three year period must be properly recognized in the current year calculation. The placement of rebate payments and liability amounts may very well be different for the Supplemental Health Care Exhibit and for the 'normal' pages of the financial statements. For example, one of our proposed changes to the Supplemental Exhibit is to move the amount of rebates paid to below the operating and net income lines. This allows the regulator to look at the operating results for the current year without them being distorted by the rebates paid for the prior year. Showing the rebate amount below the net income will allow the regulator to determine the degree to which the combination is reducing capital and surplus.

Your description of Incurred Claims is consistent with our understanding of what should be included. We would observe that the contract reserves in the Supplement should not be tied to those used in the Annual Statement. The MLRs are not designed to address the pattern of durational loss ratios that results from the sales of many individual market policies. The addition of contract reserves based on a one year or two year full preliminary term reserve basis which give relief for expenses during the first year do not match the pattern either. The use of a net level reserve basis for contract reserves for the Supplemental Exhibit would allow proper matching of revenues and expenses. We ask that the final definition clearly provide for the option to use a net level contract reserve for use in the Supplemental Exhibit.

The draft does not comment on Premium Deficiency Reserves. While these may be necessary for the annual statement and could be reported within the Supplemental Exhibit, they should be "below the lines" used for purposes of MLR calculation. Any liability for current year rebates should also be below the line so they do not impact the MLR. Reserves for future contingent benefits, however, should be designated as appropriate reserves for

inclusion within the determination of incurred claims – i.e. above the line - as they relate to likely claims based on current coverage.

We support the continued use of the Academy of Actuaries to develop an appropriate scale of tolerance values to address the potential lack of credibility in the results of small plans. We note that these factors could be different for each of the individual, small group and large group lines to recognize the different levels of benefits and deductibles commonly used in each line.

We note the comments in the last paragraph under Credibility and Pooling. Appropriate credibility and pooling mechanisms can help address concerns regarding limited aggregation. However, there are other factors to consider as well. The process for calculation of rebates should address durational issues and other factors related to the current market environment that impact the design of coverage today and that are not expected to change until 2014. Not addressing these issues threatens stability in the market and access to coverage options. In this regard, we would like your subgroup to consider transition rules along the lines we describe in the attachment or other methods to address the issues we have discussed above and in our transition discussion.

We support your description of the elements of the denominator.

With respect to the calculation procedures, we support the use of the calendar year as the basis of reporting. We believe that when you develop the rebate calculation that it should be due later than March 31st. Additional time will reduce the impact of estimates to both earned premiums (especially for large groups) and incurred claims, The determination of which claims meet the requirement for pooling, because they exceed the maximum specified amount, will not be easy using the suggested reporting date. To the extent a rebate is paid, we support payment to policyholders.

We believe that the rebate calculation should ignore the results for any policy that does not have a full twelve months of experience at the end of the calendar year. This approach is used in the Medicare Supplement Refund calculation to recognize that claims occur on average latter in any year than earned premiums which are more equally distributed. This could be added to the calculation procedures as they are more fully developed.

We thank you for the opportunity to provide comments. We anticipate providing further comments on outstanding issues such as smaller plans, different types of plans and newer plans. If you have any questions or comments please feel free to contact me at (623) 780.0260 or at omegasquared@msn.com.

Sincerely,
Bill Weller

c/c: John Engelhardt, NAIC Staff
Randi Reichel, AHIP
Shari Westerfield, BCBSA

Special Considerations for Transition and Newer Plans

A large portion of the in force policies in the individual market have been designed to comply with the existing state-based MLR requirements on a lifetime loss ratio basis. These policies will continue to be issued in order to provide individuals and families access to coverage for most of 2010 as the final PPACA regulations are being developed. Once those regulations are finalized, there will be a potentially significant delay while carriers file new rates. Most policies using updated rates will not be sold until sometime during 2011.

In addition, a large portion of the in force policies in the individual market will continue, until 2014, to show a pattern of increasing durational loss ratios and, to ensure stability in the market, will need to be priced based on a lifetime loss ratio. Prior to the full implementation of the insurance exchanges in 2014, many individuals and small businesses will continue to rely on the current distribution systems to find the policies that best meet their individual needs. If the MLR calculations used until 2014 do not take into account the durational loss ratio patterns that exist in the individual market today and will continue through 2014, many health plans may not be able to continue offering coverage in the individual and small group markets prior to 2014 - resulting in fewer coverage options for consumers.

Thus, during the transition period from 2011 until 2014, there should be specified approaches for states to adopt that, as PPACA requires, take into account the special circumstances for smaller plans (e.g., credibility adjustment), different types of plans (e.g., transition from current lifetime loss ratios to PPACA MLRs) and newer plans (e.g., first year business and individual products with durational loss ratios).

For example, States could be provided with rebate calculation rules that allow for transition from the existing state's lifetime loss ratio (used for 2011) to the State's PPACA MLR for 2014 with equal steps in 2012 and 2013. Since claims experience for individual and small group increases as the duration of each policy increases, the transition rules could also allow for the use of duration adjustments to the State's lifetime loss ratio.

In addition, amounts from policies in their earliest years would be "reserved" until the block has matured to a seasoned level where annual MLRs could be applied. To the extent that the use of net level contract reserves does not fully recognize this, a separate reserve within the rebate calculation could be developed. Existing policies have higher costs in the first year already embedded in them, and the claims experience has not had sufficient time to develop. We are concerned that many products available in the market that will have a durational loss ratio pattern may no longer be viable in the transition years without a similar reserving, creating significant stability and access to coverage issues for consumers.

