



May 24, 2010

Mr. Lou Felice  
Chair, Health Reform Solvency Impact (E) Subgroup  
C/- New York Department of Insurance  
25 Beaver Street  
New York, New York 10004-2319

RE: *Health Reform Blanks Proposal – May 20 Exposure Draft*

Dear Mr. Felice:

We write today on behalf of America's Health Insurance Plans (AHIP) to provide the Health Reform Solvency Impact (E) Subgroup with input and comments on the Subgroup's new exposure of a Blanks proposal relating to the reporting of Medical Loss Ratio information 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* for ease of reference). 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 structure to oversee United States insurers, particularly those in the health sector.

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)." It is our understanding that the most time critical elements of the exposed form are the Parts 1, 2 and 3 and that the Instructions will involve further joint efforts involving the AHWG PPACA Subgroup with your subgroup. We will, therefore, focus on the lines and columns while addressing some comments on the Instructions. We also believe that this Supplement is not meant for the calculation of rebates, only the Statutory recognition of payments and liabilities relating to rebates. If this is incorrect, we would add significant comments with respect to the manner in which rebates are calculated from the information to be reported in this Supplement.

### Proposal Form

1. **File annually.** We do not believe that this Supplement needs to be filed on a quarterly basis. The expanded reporting segmentation in this Supplement is not consistent with the reporting in the normal quarterly blanks and so will require the allocation of innumerable values in the quarterly statement without the amount of time companies expend to complete the more involved annual statement. For solvency purposes, we

believe that the reporting, without separating by line of business, of certain key expense components should be sufficient for regulators to make any actionable determination of solvency concerns. The loss ratio results for the quarterly statement (on a state-by-state basis) would be of little value for solvency and would be of no value with respect to the reporting of MLRs. The impact of rate increases, annual deductible and seasonal variations means that MLRs will vary by quarter even if the amount of business could be credible on a quarterly basis.

2. **Anticipated Effective Date.** We recognize the technical complexity associated with this Supplement, and recognize its significance starting with MLR reporting for calendar year 2011. There may be merit in a *test* filing of the Supplement for 2010, using grand totals, due by July 31, 2011 (consistent with our recommendation 3 below, and the proposed June 30 run-out date in the draft from the AHWG PPACA Subgroup) so that both carriers and regulators can learn from the work involved.
3. **Supplement Due Date.** We believe that this Supplement should be filed at the same time as the rebate calculation form (still to be developed) is due. This will avoid having multiple MLR values based on different periods for tracking incurred claims through to the actual payment. We believe that the comparison of details behind the MLRs that will be reported and the values behind the rebates need to be consistent. We do not believe that there is the same need to maintain consistency to the values reported in the Annual Statement.

### Supplemental Health Care Exhibit – Parts 1 and 2

1. With respect to the *General Instructions and Column Instructions* section, we are not convinced that the Supplement values will be able to be directly related to the Statutory Annual financial statements. As an example, we note that, within a state-based approach, the AHWG PPACA Subgroup is looking into allowing for ‘pooling’ across lines and states and possibly outside the legal entity as appropriate ways to reduce the volatility of annual MLRs. In addition, the treatment of association business in the Supplement is not consistent with the Annual Statement. Similar to the reconciliation of Statutory to GAAP financials, it may be more appropriate to start with a generalized requirement to reconcile in an attachment which focuses on the Supplement’s Grand Total parts and the Annual Statement. This would mean that many of the lines in the Supplement could be removed (especially on the state portions) and regulators could review the methods carriers use to reconcile. At some later date, based on the early experience, a standard reconciliation approach could be developed if it was determined that such was necessary.
2. The third sentence in the second paragraph of these instructions should read “ The allocation of premium and claims between jurisdictions” – so that claims are connect to the premiums.

3. We do not believe that this Supplement should redefine the “situs of the contract”. At a minimum, better wording would be:  
For individual business sold through an association, allocation shall be based on the issue state of the certificate of coverage. For small employer business issued through a group trust, allocation shall be based on the location of the small employer.
4. Similarly, the paragraph dealing with packages provided to group employers may work where this is not a significant portion of a legal entity’s large group line. Many large groups will have a diverse population across many geographic areas yet utilize a common per employee premiums scale. Differences in reimbursement rates, frequency of use of various medical protocols vary greatly across the country. Requiring the reporting of these average premiums for each legal entity is likely to result in the improper allocation of premiums in relation to claims. It may be possible that the AHWG PPACA Subgroup will provide for pooling within their work. If not, we will need to revisit this issue in the further development of instructions.
5. We support the revision reflecting Uninsured Plans as a column and not lines. We recommend that the term “Uninsured Plans” be used throughout replacing “self-insured” where that term is used.
6. We believe that the statement with respect to policies to be included in Small Group Employers should include an additional sentence: The reporting of experience for groups above the state’s Small Employer Groups maximum number of employees is for purposes of this Supplement only and does not revise state laws applicable only to Small Employers as defined in such laws.

#### Supplemental Health Care Exhibit – Part 1

7. With respect to the *Earned Premium* section, we continue to express a desire to allow for some stop-loss reinsurance and/or pooling to reduce the volatility of MLRs in each of the columns for each state. Wide ranging MLR values based on where the highest claims occur in any one year are not representative of any meaningful statistic.

For lines 1.5 through 1.8 we recommend clarifying whether it is anticipated that reporting will be necessary beyond columns 1, 2, 3, and 9. That appears to be the assumption in the instructions, but there are no “XXXs” in the remaining columns, nor is the ‘Exclude’ language clear. There does not appear any authority in PPACA for the exclusions for lines 1.5 and 1.6.

The instruction for line 1.7 should read: State and Local premium taxes plus state taxes based on policy reserves, if in lieu of premium taxes. We do not believe the last sentence is appropriate for this line. The next paragraph should be limited to the “state premium tax rate times the allocated premium amount.” With respect to line 1.8, it should include

expenses for regulatory bodies that serve in lieu of the insurance department. We do not see the basis for excluding fees for normal examinations. Finally, we support the addition of line 1.12 and its instructions.

8. With respect to the section on *Incurred Claims*, it would appear that the instructions for line 2.1 of Part 1 should be separately describing the development of the various portions of Part 2 so that the changes in reserve amounts do not get double counted. The description of the various sub-parts of incurred claims should apply to lines 2.1 through 2.10, except as noted below with respect to line 2.8. Then the Include/Exclude would focus on specific lines in the second section of Part 2.
9. *Rebates* (line 4.3) – We recommend, as in our earlier proposed changes, that rebates paid during the year as well as information on rebate liabilities be added as lines below the net gain or (loss) line. This allows the net gain or (loss) to relate to the current year unaffected by rebates. This is important for both the solvency aspects of regulatory review but also so the Supplement can be useful to regulators involved in the rate review aspects of PPACA.
10. *Incurred Medical Incentive Pools and Bonuses* (line 3) should be “From page X” and Part 2 lines 2.8 should be separated into a third subsection using lines 2.8a through 2.8c as lines 3.1 through 3.3 to produce a line 3.4.
11. *Medical Loss Ratio* (line 6) – We do not believe that the reported results will provide a credible value in many situations, and may instead reflect significant volatility. As we proposed in our prior comments, we recommend that this section add lines to reflect adjustments due to the lack of credibility from random variability in incurred claims (the impact of “smaller plans”). Consistent with the statute’s requirement to consider “special circumstances”, we believe another line should be included to reflect adjustments for “newer plans” and “different types of plans” that would deal with policies that were not priced to an annual loss ratio standard, nor set at PPACA levels, and which should be given time to allow re-pricing to take effect. This will be particularly important during the transition to 2014.

We note also that PPACA requires the carrier to report their MLR include all loss adjustment expenses in the numerator – section 2718(a), in the first sentence.

12. *Expenses (lines 7 and 9)* – We suggest that the following language be added to these lines to insure that expenses are not included in two or more places and that line 7.1 can be just “Cost containment expenses”:  
For Line 7: Claim Adjustment Expenses not included as expenses in line 5.4  
For Line 9: General and Administrative (G&A) Expenses not included in line 5.4 or line 7.3

13. **Other Indicators** – We recommend that you add a sentence prior to Line 1 which would read: “These should be allocated to jurisdictions in the same manner as premium.”

### Supplemental Health Care Exhibit – Part 2

14. We recommend that the columns for Part 2 match the first seven columns from Part 1.
15. As noted above, we would recommend that there be a separate subsection to deal with Incurred Medical Incentive Pools and Bonuses only because they generate a separate line in Part 1 (line 3).
16. As noted above, certain items that only appear in Part 2, because they feed into the calculation of earned premium and incurred claims are described in the instructions for Part 1. We believe this has the potential to be confusing, and in order to provide greater clarity recommend providing instructions in the Part where a particular term is used. For example, “Change in Contract Reserves” no longer appears in Part 1 while the beginning and ending values of “Direct Contract Reserves” are lines in Part 2 but also would be reported within line 2 as the instructions currently read. As we have proposed in our previous comments, the contract reserve amounts for this Supplement could possibly be on a different basis than what is reported for in the main blank.

### Instructions Regarding Expenses for Health Quality Improvements page 11 (should move to the instructions related to Supplemental Health Care Exhibit – Part 3)

17. We appreciate the changes in the May 20<sup>th</sup> Draft Exposure that added additional details regarding health care quality expenses. In order to ensure that key quality initiatives are supported, we urge consideration of the following additional points:
- **Care coordination:** The language “direct interaction between the insurer and the enrollee” to coordinate care is unnecessarily limiting. There are cases where the insurer interacts directly with providers to coordinate care, and the providers communicate directly with the enrollee/patient. This is especially true when the enrollee is an inpatient at the time, and the coordination is for transition of care – or to rehab units, etc. Thus we recommend the deletion of that language, beginning the paragraph (after the parentheses) “to coordinate a patient’s care...”
  - **Acute Care case management:** many activities of **Care coordination** are related to acute care situations, such as helping assure quality care and coordination with joint replacement surgery, at-risk pregnancy management, transplants, etc. We urge the inclusion of language referencing “*including acute care*” in the first category of quality initiatives.

- **Nurse hotlines:** Many of the calls to nurse help-lines are related to emerging acute care issues, or to obtain assistance in coordinating an episode of treatment. Nurse help-line calls are also valuable decision support tools that enrollees use in managing their own care. That either needs to be explicitly added to the three grouping categories, or the exclusion of nurse hotlines needs to be removed, as still too limiting.
- **Preventive Care and Wellness Programs:** Language referring to “hands on” programs remained in this section, although there is clear recognition of the value of coaching, assessments, etc. Thus that language should be removed.
- **Quality reporting activities:** many States and Federal programs require certain quality assurance and quality improvement activities and reports. Quality activities such as those related to completing the HEDIS and CAHPS reports are not just health IT, but include having nurse managers pull files and review patient cases. Such quality review is required as part of the NCQA and URAQ certification health plans undergo. We recommend recognition of those be added in the language under **Other costs**. Here is the proposed revision:
  - *Other costs for quality improvement initiatives required by states, state programs or federal programs, or as required by, or approved by the Secretary in consultation with the NAIC. This includes quality expenses related to activities performed in developing required reports, such as chart reviews and surveys related to HEDIS and CAHPS reports.*
- **HIT expenses:** The language in section Line 5.2 is very specific in limiting the expenses to technology costs. We recommend the re-insertion of the previous language permitting “other costs as approved by the Secretary” in this section, and the related column for other approved HIT expenses reinserted back into the Exhibit – Part 3 (at page 5 of the May 20<sup>th</sup> exposure draft).
- **HIT expenses exclusions:** We agree, routine upgrades to systems are not quality expenses. However, this language would appear to exclude the transformation of the health care system to the ICD-10 detailed code sets. These updated codes, required by the new federal standards, should be a permitted quality expense, as they explicitly facilitate quality improvements in the three items listed in 5.2 . There are numerous places in regulations where HHS states the reason for adoption of ICD-10 is to improve quality and patient safety. (See 74 Fed.Reg. January 16, 2009 at 3330, 3332, 3339 and 3348.) We recommend affirmatively add “including those related to implementation of ICD-10” in the 1<sup>st</sup> paragraph of 5.2. Here is a proposed revision:

- *The PPA CA also contemplates "Health Information Technology" as a function that may in whole or in part improve quality of care. Include health information technology expenses, including those related to implementation of ICD-10, required to accomplish...*

18. A further concern regarding Supplemental Health Care Exhibit – Part 3 is that it appears to expect insurers to break out such costs by state, rather than by programs. Consistent with a state-based supplement, this information could be provided at an aggregate level with an explanation of the method the company used to allocate lines 1.10, 2.10 and 3.10 of Part 3 into the appropriate lines of Part 1 for the various states. This recognizes that companies will often be implementing the programs addressed in Part 3 of the Supplement across their book of business, and thus will need to rely on allocations to provide information at a state level. Including key values used for allocation purposes (earned premium, incurred claims, number of lives) would allow the evaluation of the reported expenses in respect to the business involved while assuring the regulators that they have sufficient information about the allocations to assess their fairness in total.

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 Bill Weller at (623) 780.0260 or at [omegasquared@msn.com](mailto:omegasquared@msn.com), Randi Reichel at (301) 774.2268 or [rreichel01@comcast.net](mailto:rreichel01@comcast.net), Candy Gallaher (202)641-2492 ([candy.gallaher@ahip.org](mailto:candy.gallaher@ahip.org)).

Thank you.

Sincerely,



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Cc: Randi Reichel  
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