May 8, 2010

To: Lou Felice  
   Chair, Health Care Reform Solvency Impact Subgroup, NAIC

   Steven Ostlund  
   Chair, Accident & Health Working Group, NAIC

   Julia Philips  
   Chair, Rate Review Subgroup, NAIC

From: Mike Abroe  
   Chair, Premium Review Work Group  
   American Academy of Actuaries

Re: Considerations Relating to PPACA Premium Review Provisions (Section 2794)

Dear Lou, Steve and Julia:

The American Academy of Actuaries1 (Academy) Health Practice Council has formed several work groups to focus on specific implementation issues relating to the passage in March of the Patient Protection and Affordable Care Act (PPACA). The Premium Review Work Group is focused on the provision addressing unreasonable rate increases to be reported by health insurance issuers included in Section 2794 of the Public Health Service Act (PHSA), which was added by PPACA.

Our work group is in the process of analyzing Section 2794, as well as preparing a response to the request for comments on Section 2794 issued by the U. S. Departments of Treasury, Labor, and Health and Human Services and published in the Federal Register on April 14, 2010. In our group’s initial conversations, we have quickly concluded that there are a number of important questions that need to be addressed. Given the long history of cooperation between the Academy and the NAIC on regulatory issues, we wanted to reach out to NAIC at an early stage of the PPACA implementation process in order to provide input on issues that we believe are particularly important to your work.

In this letter, we have identified several key questions. These are not the only questions that we have related to Section 2794; however, we believe those framed may be the most relevant to

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1 The American Academy of Actuaries is a 16,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
your work as the NAIC develops its own comments and requests for clarification related to Section 2794.

1. Section 2794 is silent with respect to the market segments that will fall under the rate review provision. Will these affected market segments be consistent with market segments that fall under the minimum loss ratio provisions of Section 2718, or will they be different and specified in regulation? In either case, the review process would likely vary significantly by market for various reasons. Since the review process is of company rates, we believe the focus should be on what companies will file:

   a. Group (large and small)—For insured groups, the starting point for calculation of premiums and premium increases is the rate manual. One approach for reviewing rates would be to track changes in the rate manual or manuals maintained by the companies.

   b. Individual—For individual products, rate tables and the table increases are typically based on achievement of a set of durational and lifetime loss ratios. The tables are filed with and commonly approved by states. One approach for reviewing rates would be to track changes in the approved rate tables by form.

2. Section 2794 of PPACA contains language referring to a process for an annual review. There is an initial premium review process that addresses premium renewals that would be subject to higher rates prior to 2014. There is a continuing premium review process that could expand upon the initial process, but it would apply additional rules relative to products sold in the exchanges. Alternatively, this could be a replacement for the initial process. It is not clear which interpretation is appropriate.

The issues below are framed with an assumption that the initial process is continued but possibly modified to reflect the addition of exchange premiums. The initial review process requirements are:

Section 2794 (a)(1)(2)
“(a) INITIAL PREMIUM REVIEW PROCESS.—
“(1) IN GENERAL.—The Secretary, in conjunction with States, shall establish a process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.

“(2) JUSTIFICATION AND DISCLOSURE.—The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers.”

The term “annual review” could mean a single, short period during which premium rate increases that have been filed with a state(s) over some prior period are reviewed. This seems consistent with the requirement in (b)(1)(A) to “provide the Secretary with trends in premium increases.” [emphasis added] Since companies will be filing for premium rate increases
throughout the year, it would appear that the states alone will make the determination of which premium increases are unreasonable and those increases would be subject to the annual review. Under this approach, a company would provide the HHS Secretary and the relevant state with its justification for such increases following the state’s approval of the increase. A company could implement this increase without regard to the annual review period.

Another interpretation is that the annual review process relates to anticipated filing of rate increases on an annual basis. Under this approach, the Secretary would potentially need to be involved whenever a premium increase meets the state’s definition of “unreasonable.” This would extend the period of time until any rate increase is implemented. We are concerned that such delays will create the need for larger rate increases in the future, as the costs of the coverage are ongoing and will continue to increase whether rates are increased or not.

We note that many states have a process called “file and use” under which companies may file premium rate increases and implement them prior to the state’s review of the increases. Companies are careful to follow the rules of these states so that when a state reviews the rates (sometimes after they are in effect), a company does not have to adjust premiums for periods that have already passed. Assuming a clearly defined standard for “unreasonable rate increases,” states that use this approach may continue to allow “file and use” for rate increases under that state’s standard but require prior approval for any increase that exceeds the standard for what is deemed reasonable. The annual review process would not seem to apply to these increases, but clarification is important.

Will the NAIC establish a required uniform method for these reviews or will there be variability allowed on a state-by-state basis? How will differences in approval processes be resolved between states, especially once the exchanges become a significant source of coverage?

The manner in which the Secretary would monitor premium increases under (b)(2) could be limited to the review of only unreasonable rate increases, but it may be more useful to focus on the increases that result from maintaining actuarially sound premiums from period to period.

**Proposed Approach for Reasonable/Unreasonable Rate Increases**

We propose an approach whereby a reasonable increase in premiums is defined as the change in actuarially sound premiums. An actuarially sound premium is one in which the rate-setting process is consistent with Actuarial Standards of Practice (ASOPs), the Code of Conduct promulgated by the Academy and adopted by the five U.S. actuarial organizations, and/or applicable law. All assumptions underlying the determination of premiums would be identified, and documentation would be available for the state actuary to review. The state and company actuaries should agree on assumptions; however, the NAIC may want to consider ways to address situations in which the two actuaries are not able to reach an agreement quickly. It should be noted that actuarially sound premiums, and the resulting increases, may vary between companies based on the companies’ underlying assumptions.
Experience subsequent to that used in developing the current premiums may imply current premiums are too high or too low. Regardless, such experience would be used in developing the new premiums. However, the rate increase would be still deemed reasonable as it would be based on the increase in two actuarially sound premiums; therefore, the definition of an unreasonable rate increase should not be a simple percentage.

We would expect states to have a process for rate review that allows for the timely use of new actuarially sound premiums, within which increases based on such actuarially sound premiums would not be considered unreasonable.

Some increases to reasonable rates will be larger than others. Variations in deductibles and other components of the benefits will produce different medical cost trends for different products, yet those would still be reasonable under this approach if both prior and current rates are actuarially sound.

Delays in implementing actuarially sound premiums will result in larger rate increases at future filing dates. The process for the annual review involving the Secretary should not delay any rate approval process. The manner in which the Secretary could monitor premium increases could focus on the maintenance of actuarially sound premiums from period to period. The amount or percentage of premium increases across a wide range of companies analyzed as part of this monitoring could focus on the critical connection between premium rates and the underlying increases in medical costs.

To assist consumers and help in the rate review process, we suggest developing categories of rate increases such as:

a. Reasonable, without additional justification;

b. Reasonable, based on additional solvency requirements;

c. Reasonable, based on other justifiable factors; or

d. Unreasonable, not justified.

3. If the approach above is implemented, or even if another approach used, there are a number of issues that will need to be addressed. We outline below some of these issues:

   a. Will the unreasonable rate increase standard or standards be published so insurers and consumers will know what the parameters are and how the process will work?

   b. Will the basis used to determine if an increase is unreasonable be clear-cut so that the insurer will know in advance of filing? Or will it be a determination made by states during the review? Or will the determination be made at some later date?

   c. For all increases that are to be reviewed, will any circumstances be considered de facto not unreasonable? For example if an insurer is operating at a medical loss ratio (MLR) significantly in excess of the minimum which ultimately will impair solvency, is there such a thing as unreasonable rate increases?
d. Is the reasonability of an increase determined at the individual or group health level or some other level? For instance, if the increase is different for different benefit types, how finely would the unreasonable label be applied?

e. Is the concept of unreasonable premium increase limited to renewing business? In other words, is changing new business premiums outside the scope of unreasonable premium increases?

f. Will solvency concerns be a necessary part for the approval of an unreasonable rate increase? If so, will the solvency standards be stated?

g. Will rate adequacy be a necessary factor for the approval of an unreasonable rate increase?

h. If a state review determines that an increase is unreasonable, a justification for the public will be prepared. Will the justification be reviewed by the state? How will an insurer know in advance that justification is needed? Will it require review from state policy forms experts or merely state rate experts? How long will it take to get approval for public release?

i. What changes, if any, will need to be made to the state rules regarding notification and approval of a premium change? It would appear that timely review and communication of rate changes will be necessary. It wouldn’t make sense for companies having to delay implementation of approved rates.

4. What is the definition of “plan year?”

The beginning of any plan year after 9/23/2010 will be the date a state’s definition of unreasonable rate increase is published and shall only apply to rate increase filings submitted, if required to be submitted, after such date. Is this a correct interpretation?

Another possibility is to define plan year as the calendar period during which states accumulate information for purposes of the annual review with the Secretary.

5. We believe special considerations should be given to grandfathered business. The manner in which these considerations would be accomplished will likely depend upon the answers to the following questions:

a. Will individual grandfathered business be subject to both lifetime and annual loss ratio requirements?

We believe that individual grandfathered business subject to lifetime loss ratios should not involve the MLR requirements within the rate review process.

b. Will there be transition rules for current business?
For grandfathered group business, a short transition period would be useful and appropriate since this business has been typically rated on a year-by-year basis.

For individual business, no transition rules would be needed for the rate review process; however, transition rules would appear to be needed for application of the MLR requirements because of the historical durational loss patterns.

c. As the number of lives in grandfathered business decreases over time, we suggest pooling should be considered to increase rate stability and credibility.

* * * * *

We hope these questions are helpful to you as the NAIC commences its work on Section 2794 implementation issues. If you have any immediate questions regarding this letter, please contact Heather Jerbi, the Academy’s senior federal health policy analyst, at jerbi@actuary.org or 202.785.7869.

Sincerely,

Michael S. Abroe, FSA, MAAA
Chairperson, Premium Review Work Group
American Academy of Actuaries

Cc: Jay Angoff, Director, Office of Consumer Information and Insurance Oversight, HHS
    Richard Kronick, Deputy Assistant Secretary, Health Policy, HHS
Dear Mr. Felice:

I am writing to express the views of the Alliance of Community Health Plans (ACHP) on issues related to the calculation of Medical Loss Ratio. ACHP members are non-profit, community-based and regional health plans or subsidiaries of non-profit health systems. They deliver health care and provide coverage for approximately 18 million Americans and 15 percent of Medicare Advantage enrollees, predominantly in the individual and small and mid-sized group markets. Among our members are many of the high-performing health plans cited by the President and Congressional leaders as models of coordinated care or integrated delivery systems. Member plans share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide coordinated, affordable, and high quality care.

ACHP offers the following recommendations on the discussion draft circulated on May 5:

**Definition of Quality-Related Activities:** On the May 5 conference call, Commissioner Praeger and others made the point that quality improvement models continue to evolve and that definitions will have to be modified over time. We agree, and believe that the category of quality-related activities should be broadly defined and flexible. While the draft Instructions for Line 5 entries appear to provide a relatively broad definition of expenses that are “designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care,” the expenses to be included on lines 5.1 and 5.2 are very narrowly drawn and seem to focus only on health promotion and wellness programs directed to insured members. There are many other expenses incurred by our member plans and clinical staffs that improve the quality of care. To cite just a few examples:

- activities to coordinate care across settings – e.g., transitions-in-care programs to assure that preventable rehospitalizations are avoided or minimized and that a patient receives necessary care and complies with prescriptions and other medical directions after a hospital discharge;
- support for programs that involve the patient in shared decision-making regarding treatment options;
- care management activities, including assistance to patients in navigating across the continuum of care, avoiding unnecessary care, or seeking care in an inappropriate setting;
- development of practice guidelines and other medical management activities designed to reduce variation in care and inappropriate use of services;
- expenses related to accreditation and to collection and reporting of quality measures; and
- development of patient-centered medical homes and other models to transform primary care.
We would also point out that many quality-related activities have cost containment implications but that they appropriately belong in the MLR numerator as activities that improve health care quality. One example is activities designed to reduce hospital readmissions. Another example is investments in information technology upgrades that improve information sharing among providers, health plans and patients. These activities clearly have a cost containment impact, but we would argue that they are very much focused on quality of care, have a direct impact on individual enrollees, and should be included in the category of quality-related expenses.

These and other examples suggest the need for an approach that might focus on the characteristics or purposes of quality-related activities, and might set criteria for inclusion, but does not attempt to specify a list. Because this is a new component of MLR calculations, because Congress provided little guidance, and there is a paucity of research or regulatory experience to provide precedents for this new category, neither NAIC nor HHS should be overly prescriptive. We believe that these factors argue in favor of starting with a broader and more inclusive definition and encouraging HHS to establish a consultative process for the development of criteria that differentiate activities that improve quality from those that serve other purposes. We also agree with comments that were made on the conference call that NAIC should recommend that HHS will need an ongoing process to modify this category of expenses over time as new approaches are developed.

**Community Benefit Activities:** As not-for-profit plans or subsidiaries of not-for-profit systems, ACHP member organizations incur significant expenses for community benefit activities. These typically involve cancer screening, immunizations, and a wide range of health education programs for the community. Community benefit expenses are incurred in lieu of income taxes that would be paid by for-profit companies. While those taxes will be subtracted from total premium revenues in the denominator of the MLR calculation, not-for-profit plans will be put at a disadvantage if community benefit activities that they pay for in lieu of taxes are not similarly considered in the MLR. We strongly encourage NAIC to recommend that community benefit expenses be included as part of the category of activities that improve health care quality. We would point out that there is nothing in the legislation that restricts quality-related activities to those that are directed at enrollees, and we urge NAIC not to tie these expenses to enrollees only, particularly for not-for-profit organizations that have a broader mission of improving the overall health of the communities they serve.

**Three-Year Rolling Average:** As you know, MLR can fluctuate significantly from year to year. The legislation seems to recognize that variation by calling for the calculation of a three-year average MLR starting in 2014. We encourage NAIC to acknowledge both the variability of MLR and the uncertainties of adopting standard definitions and methodologies on a national basis for the first time by recommending to HHS that a three-year rolling average should also be used from the start as a mechanism for transitioning to and achieving compliance with MLR reporting and rebate requirements.

**Aggregation Level:** ACHP recommends that MLR calculations and reporting should be at the state level. That is the level that would be most meaningful to consumers, most appropriate to reflect different business and regulatory environments among the states, and most consistent with current reporting requirements. We also believe that calculations should be based on where the site of the contract is and not on where individuals reside, which is likely to introduce inaccuracies in reporting.
**Incentive and Bonus Payments**: We are pleased that NAIC proposes including medical incentive pools and bonus payments on line 3 as part of incurred claims. ACHP member health plans have implemented a variety of incentive arrangements, not all of which are shared savings agreements. We recommend adding the following underlined addition to this sentence: “Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to share savings with contracted providers or rewards providers for delivering high quality services.”

**State Taxes and Assessments/Fees**: It appears that the discussion draft includes major categories of state taxes, assessments, and fees, including high-risk pools or other assessments to provide health care for individuals who do not have coverage. Some states use assessments to fund public health types of activities, and we encourage you to allow leeway for inclusion of these assessments. The more general point is similar to the one made above for quality-related activities: Given the wide range of assessments and fees across the states, we encourage you to recommend that HHS interpret this category broadly and with flexibility so that health plans can include all of the taxes, assessments, and fees that they are required by states and other authorities to pay.

Thank you for your consideration of our views. Please let me know if you have any questions about these recommendations or require additional information.

Sincerely,

Patricia P. Smith
President and CEO
### ACHP Member Organizations

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May 06, 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: Medical Loss Ratios

Dear Mr. Felice:

I 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 charge to develop 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 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 regime 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).”

We reviewed the blanks proposal recently exposed by the Subgroup. We have a number of comments and concerns.

I. General Comments

As a general comment we believe it critical to keep the ultimate goal of the medical loss ratio in mind – to ensure that consumers receive appropriate and quality care for their premium dollars. To that end it is similarly critical that as the ratio is developed, definitions and methodologies not be structured in a way that harms consumers by reducing choice among carriers or providers, reducing solvency for carriers, or reducing the ability of carriers to maintain quality standards, or interferes with the provision and promotion of high quality health care benefits through high quality providers. To the extent that the regulatory system
for 2718 sets up a paradigm under which carriers are penalized for providing these high quality services to their enrollees and beneficiaries, it will not meet these goals. The comments below are designed to improve the draft reporting format and provide suggestions with respect to definitions that we believe will enhance the manner in which states meet their requirements under 2718.

Also as a preliminary comment, we note that there is no indication in the draft proposal when the supplemental health care exhibit should be filed. We urge the subgroup to consider a delayed filing date, similar to the Medicare Supplement deadline to permit increased accuracy in the claims and premium data being submitted. We suggest an annual deadline of July 1 and recommend federal filings be made consistent with that timing.

We also question the column for “grandfathered” individual plans. We note that there are no similar columns for large and small group, but suggest that it is not necessary to include it for any of the three categories of plans. Requiring carriers to allocate all their company-wide expenses not only by individual, small group and large group but to also further break down individual into pre-and post reform categories makes the allocations meaningless. Carriers will have a significantly more difficult time providing timely and accurate information with this additional breakdown, and will cause inconsistencies in reporting among plans. We suggest removing that column.

As a last general matter, we question how the exhibit will apply to insurers that do not file statutory basis.

II. Specific Comments

A. Approaches to Maintaining Stability

In general, we support a state-based approach, and to calculate a loss ratio for each insurance holding company group in each of the three market segments – large group, small group and individual. We also support making appropriate actuarial or statistical adjustments where the scale of enrollment being taken into account in the MLR calculation could create unintended volatility that drives up the cost of coverage for consumers and reduces available choices in the market.

In addition, the particular challenges of large employers should also be taken into account. Large employers often have multiple work sites and employees in many states. Reflective of this structure, carriers do not generally report MLR information on a state-by-state basis. Consequently, requiring carriers to calculate the MLR for large groups using the same precise rules as those for individual and small group coverage could result in significantly higher administrative costs at a time when carriers are being required to hold these expenditures to a minimum.¹

¹ The issues to be addressed in considering the circumstances of large-group coverage have been recognized elsewhere. According to the economist James Robinson, "This obscure statistic [the MLR] is losing whatever meaning it once had." He notes one particular issue with the MLR as: "Efforts to compute the medical loss ratio for any one geographic region require the parent company to allocate central administrative expenses to particular regions. This is particularly problematic when some products, such as those for federal employees or large corporations, are marketed and managed at the national level." (Robinson, James. "Use and Abuse of
Any solution to address these concerns should ensure accurate distribution of administrative expenses and conform calculation of the MLR with the accounting principle of matching costs to associated premiums. It should also recognize the need to ensure appropriate levels of statistical credibility as explained below.

The methodology for calculating the MLR should recognize that blocks of individual and group policies may be credible for MLR calculation purposes, that is, may have sufficient scale, at the national level but not at the state level, or they may be credible in some states, and not credible, that is, may not have sufficient scale, in others, or they may be credible within one reporting entity and not in another affiliate. A flexible process for addressing this issue 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 accumulating experience in a manner as close as possible to the experience reported for section 2718 reporting.

As discussed above, it is critical that loss ratios used for rebates meet statistical credibility standards for each of the individual, small group, and large group market segments. One way to accomplish this is to adopt a modified version of the credibility adjustment table that is included in the NAIC Annual Medicare Supplement Refund Calculation form to factor in a non-Medicare population. The MLR standards are intended to drive value for consumers by assuring more premium dollars go to patient care costs and reduce insurers’ administrative expenses. These standards, however, must guard against the unintended effect of causing volatility that could drive up the cost of health insurance coverage for consumers and reduce their choices in the marketplace. New regulations should build on the experience and lessons learned from the calculations designed for the NAIC Medicare Supplement loss ratio standards. Those standards recognized uncertainties and market selection dynamics. However, the standard for the commercial health insurance market must be adjusted to factor in the diversity and wider variation of claims costs in this population as well as comprehensive benefit plans.

The minimum MLR standards in the new federal law guarantee consumers a rebate if the standards are not met, but provide no protection against random variation in claims experience. Based upon the NAIC’s past methodology, credibility refers to having a sufficient number of covered lives within a state. If an insurer has low membership, its block of business is too small and the experience will meet credibility standards. Health claims are not predictable and can vary significantly from year to year with the range of variability depending on the insurer's volume of business. Unless an insurer has significant volume the MLR and rebates will vary significantly from year to year and the rebates could result from just normal variation. For example, the insurer could be targeting an 80% MLR,

the Medical Loss Ratio to Measure Health Plan Performance." Health Affairs, Volume 16, Number 4, p. 176-187.)
but yet end up paying a significant rebate one year and incurring a substantially higher MLR in another year from normal claim variation. The smaller the insurer’s block of business, the greater the likelihood of this type of variation from year to year.

The NAIC methodology addressed some of the claim variation by adopting a credibility or tolerance adjustment to the MLR based on the number of policyholders and the length of time they held their policies. No rebate was required if the policy loss ratio was based on less than 500 life-years exposure. The rationale for this adjustment was to ensure that rebates would not occur so frequently in the early years of the policy experience that large premium increases could result in later years.

We propose the following statistical credibility adjustment table based on the methodology used in the NAIC Annual Medicare Supplement Refund Calculation methodology.

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<td>&lt;1000</td>
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The proposed adjustment would recognize that the random variation and difficulty in accurately predicting the MLR of small, diverse populations in the medical market is significantly higher than in the Medicare Supplement market.

If a credibility adjustment is not included in the MLR calculation, it will result in unstable premium rates due to claims volatility. Claims variability could cause insurers to experience MLRs higher than the minimum that generate financial losses. These losses could force insurers to face solvency challenges. Additionally, carriers may be forced to exit or not enter new states. This will leave consumers with less affordable coverage options due to the lack of market competition.

Additionally, the ability of new insurers to enter markets, or existing insurers to develop new, innovative products will be stifled without a minimum size threshold. In the initial phases of a product life cycle, pricing is difficult to determine (in any industry); the proposed credibility table will allow for appropriate pricing adjustments, insuring attainment of minimum loss ratio requirements, as product sales grow and mature.
B. Scope of coverage

We note that the interim final rule regarding the web portal has just been released for comment from the Department of Health and Human Services (HHS). In it, the agency specifically mentions that "individual health insurance" under PPACA does not include short-term limited duration individual medical insurance, by reference to Section 2791(b)(5) of the PHS Act. We therefore expect that if short-term limited duration individual medical insurance is not intended to be covered by the PPACA portal then it will similarly be exempt from the MLR reporting and rebate requirements. This means that, for purposes of the blanks proposal, the “Individual” column needs to be defined to exclude short-term policies.

C. Uniformity of Allocation

The recently exposed blanks proposal has once again raised the issue of allocation methodology among the states. The NAIC grappled with this issue over the course of many years. The end result of those years of discussion was an agreement that carriers could continue to use the allocation methodologies they had historically been using without incident for decades. The genesis of the debate was an attempt to force all carriers to alter their allocation methodology to report premium in Schedule T based on the number of covered lives in a state rather than according to the situs of the large group contracts. The vast majority of health carriers report their premium in Schedule T based on the jurisdiction in which the contract is sitused and have been doing so for many years. The attempt to force all carriers to change their allocation methodology was troubling, as it was disruptive, administratively impossible to do with any guaranty of accuracy and not cost-effective for any but the few handful of states that expected to receive additional premium taxes.

The industry concern was based on a number of points. First, carriers noted that there is no good policy rationale to require that health carriers divorce their existing allocation methodologies from the state that regulates their policies. If one single method nationwide needs to be developed, then health policies should be allocated to the situs of the group master policy, rather than spread among possibly every state in the country. Second, the vast majority of health insurers allocate and report premium in both the individual and group market according to the jurisdiction in which the contract is written, which is the appropriate nexus, given that it is that jurisdiction which regulates the policy and its benefits. The laws of that state will apply to the conduct of the insurer and the design of the policy. In this case and for the purposes of MLR calculations, rates are governed by the state with jurisdiction over the policy and reporting should not divorce the MLR calculation from the state that regulates that premium.

A survey of the insurance industry in 2008 revealed that a requirement that carriers alter their mechanism for premium allocation would then have cost the health insurance industry over $1 billion – just for the cost of altering the systems to reapportion premium among the states. The ongoing costs of tracking members and beneficiary movements from year to year is an additional cost that on an industry-wide basis runs to the hundreds of millions of dollars – all of which will be administrative expenses. Forcing carriers to make these changes at this time is not only burdensome, but will have a significant negative impact on consumers by imposing compliance costs on carriers that otherwise would be used to provide quality...
services to members and beneficiaries. And forcing carriers to report on a covered lives basis in this blanks proposal will create a dissonance between it and Schedule T.

Large groups, and possibly small groups once they are expanded to include up to one hundred individuals (plus beneficiaries), have beneficiaries spread throughout the United States. Tracking the location of each individual within the group is impossible given the mobility of the United States workforce. Individuals cannot be forced to report changes in location to their insurers, so no state would ever be certain that the “head count” is accurate. If the concern is that rebates, should one be ordered, be returned to the appropriate individuals, then the only way to fairly provide for that is to require that a rebate in the group market be returned to the location where the premium was received – that is, the situs of the group contract. The employer in the state will then return the employees share of the rebates to the employees who paid into the contract, no matter their geographic location. That is much more rational, and fair to the individuals whose premium is being counted, than to order a rebate to individuals in a state who may have had nothing to do with developing that ratio in the first instance.

D. Taxes and other state and federal assessments

It is unclear to us why “other taxes” is in line 8.3, rather than under line 1. The “premium” line has a place for reporting state and local insurance taxes (line 1.4) and state premium taxes (line 1.5). Missing is a line for federal taxes of any kind and even if line 8.3 were moved under Line 1, there is still no line for federal income or other taxes. PPACA does not make the distinction that this blanks proposal does with respect to state versus federal taxes, or between insurance versus non-insurance taxes. The language in this case is simple, and clear. All “Federal and State taxes and licensing or regulatory fees” are to be deducted from the report on non-claims costs in Section 2718(a) (3), and from the rebate calculation in (b). There is no limitation that the taxes or fees must be “insurance” taxes.

Indeed, given the premise of the MLR calculation, as noted above, it makes sense both practically and as a matter of policy to exclude all taxes related to the company’s insurance business, not only the ones currently listed under line 1. The goal of this section is to direct dollars in the health care system toward financing needed care. To the extent that there are categories of expenses imposed by governmental entities that are fixed and immutable, failing to deduct these categories penalizes policyholders. This is clearly not the intent of the medical loss ratio requirements. State and Federal income taxes, premium taxes, payroll taxes, real estate taxes, state licensing and all other regulatory and examination fees, the fees imposed by departments of insurance and health on companies as a cost of being regulated such as agent appointment fees, certificate of authority fees, Form B filing fees, and the costs to maintain a license are all fees that companies are required to bear. They should not be included in a calculation whose purpose is ultimately to limit the amount that carriers can spend on non-claims items, given that the carriers are given no choice but to carry these costs if they intend to stay in business.

In addition, we note that guaranty fund assessment, and other state assessments such as high risk pool assessments, where the carriers are already paying for the cost of care should be included in the claim section of this calculation, as more fully discussed below.
E. Reinsurance

The draft supplement requires reporting only direct business with no reflection of reinsurance. Some reflection of reinsurance is necessary, both to address past and future changes in the carrier that need to be done without cancelation of existing policies and, with sufficient regulatory oversight, the appropriate use of reinsurance in risk management. To these ends, we recommend that the following impacts of reinsurance be allowed to be reflected in Earned Premiums and Incurred Claims.

**Assumption Reinsurance** where one carrier totally replaces the originating carrier without disruption of the coverage. In addition to novation, this includes 100% reinsurance (either directed by the regulator or approved) pursuant to which the new carrier is responsible, through a reinsurance contract for the risk, and takes over the claims and other servicing responsibilities of the existing contracts. This should apply to both existing assumption reinsurance or purchase agreements as well as those that will occur in the future. In time, many of these contracts have been and will continue to be renewed into the new carrier’s products, but the management and statutory reporting occurs on the effective date of the agreement. In this case the “issuer” is the carrier responsible for pricing and servicing the policy and so should be deemed to be the assuming carrier.

**Reinsurance used for Risk Management** covers a number of types of reinsurance. Many states require certain carriers to have reinsurance for excess losses as part of their risk management. These carriers should not be penalized for complying with state requirements. Other uses of this approach to reinsurance would be to allow multiple carriers to be a combined set of issuers in offering coverage options to the covered lives of a single group using a comprehensive premium basis. Reinsurance would be used to true-up the results so there is fair risk sharing among the carriers. This type of risk pooling could be used by a number of affiliated carriers, each an issuer of health coverage, to enhance the credibility of the results for purposes of 2718 reporting.

Excess loss reinsurance should have an attachment point that is above the average claim amount of the carrier so that the amount of earned premium reduction is fairly small. This amount is likely to be fairly stable from year to year while the reinsurance recovery of incurred claims is likely to fluctuate significantly. However, the direct earned premium net of this reinsurance is also likely to be similarly stable while the incurred claims net of reinsurance will be less volatile than looking at direct results prior to this type of reinsurance. In addition, these reinsurance contracts frequently provide smaller direct writers with access to the reinsurer for information about trends and care management. To the extent the reinsurer is providing assistance that would qualify as an activity that improves health care quality, the sharing of these expenses should be recognized in the 2718 reporting.

The other uses of reinsurance will vary with the intent. We believe that the allowance for this type of reinsurance should be based on the “acceptance” of the reinsurance contract for purposes of 2718 reporting. We use a different term from “approved” reinsurance since there may be requirement for approval and use of reinsurance contracts that would not be accepted for 2718 reporting. The contracts should be presented to the domestic regulator within three months of the effective date of the risk to avoid their use when a substantial portion of the year’s experience has been developed. This type of contract is likely to define
roles and expense sharing that would impact the reporting of activities that improve health
care quality and taxes that would be subject to acceptance as well.

F. Claims

Amount paid that are the equivalent of claims, but not paid directly by the carrier, should be
reported here unless there are specific instructions to report them elsewhere. These would
include assessments that support the payment by state run pools (e.g. indigent care, CHIP
programs, high risk pools) guaranty funds or other state or federal assessment driven by the
provision of health benefits.

We believe that as part of its methodology “to account for smaller plans, different types of
plans, and newer plans” that the reporting needs to reflect a recognition that all values as
reported are not credible for the determination of rebate amounts. This could be done by
adjusting incurred claims (lines 2 through 4) or as an adjustment between the reported value
in line 6 and the value that gets used to determine the rebate amount. We recommend the
adjustment to line 6 as shown in the attachment. This is consistent with the approach used
in the Medicare Supplement Refund report as discussed above.

Assuming the draft is intended to deal with both the initial year and subsequent years, it
must address how rebates will be reflected. We urge the subgroup to calculate the MLRs
prior to rebates and reflect the percentage that becomes a dollar amount of rebate as a
separate item. The sum of the MLR and the rebate percentage would be used in developing
the three year average required by 2718(b)(1)(B)(ii). Reported values of incurred claims for
use in the next year’s calculations would not be revised to reflect the dollar amounts of
rebates.

It is important that rebates be correctly reflected when the current year’s rebate is based on
the average of three years so that rebates are not duplicated. We have proposed the manner
in which lines would be added to the draft supplement in the attachment.

G. Expenses related to improving health care quality

Both the reporting ratios and the rebate ratio recognize that health plans and insurers engage
in many activities that improve the quality of the care that health plan members and
beneficiaries receive, or that provide for a safer, more efficient health care experience for the
patient. These initiatives are required by some states, and are strongly encouraged by the
federal government through various PPACA provisions and the American Recovery and
Reinvestment Act of 2009 (“the Stimulus bill”) (Pub. L. 111-5)

It is critical that the medical loss ratio not be used as a vehicle to remove quality programs
and their benefits from policyholders. The list of programs that provide direct benefit to the
policyholders is long. It includes programs that provide nurse call lines, programs that
develop and maintain the availability of centers of or networks of excellence where patients
can receive specialized, unique or superior quality services from providers and institutions,
case and care management programs that provide coordinated care for individuals with
multiple diseases or who need assistance coordinating care, disease management where
individuals with specific disease states receive individualized care routines and regimens,
wellness programs where individuals are taught to maintain their health through individualized programs, patient monitoring programs, e-prescribing, where individuals are ensured safe quality programs and drug safety programs where individuals are protected from unsafe pharmaceuticals or harmful interactions.

Congress in the Stimulus bill recognized that investments by insurers and providers in advanced technology for medical records, e-prescribing and similar initiatives is a quality activity. The bill itself states that the programs it will fund are “designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care.” The blanks proposal here should not be a vehicle to thwart the implementation of these unique and important federal initiatives by providing roadblocks to plans and insurers wishing to take part in their development.

Similarly, the federal government has required health plans and insurers to comply with costly new administrative simplification standards pursuant to the health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2. Failing to take these mandatory expenditures into account when developing the MLR standards once again undermines a company’s ability to provide access to more and higher quality clinical services for consumers, which is contrary to the very purpose of the MLR calculation.

Not only the federal government, but also the states recognize that quality initiatives are beneficial and have taken steps to encourage – and mandate – that plans engage in them. Delaware requires carriers to maintain continuous quality improvements programs; Florida requires that states maintain accreditation with an external accrediting organization, as do Hawaii, Kentucky and 25 other states and the District of Columbia. Again, carriers should not be penalized for engaging in mandated initiatives, particularly when those initiatives are geared entirely toward providing quality care to consumers.

We urge the subgroup to avoid creating any disincentives for health plans and insurers to create, maintain or participate in programs or the development of technology that will serve to benefit consumers, and that will make their care experience safer or of higher quality. We suggest the loss ratio reflect what health plans are doing to improve quality through patient and clinical services and health information technology in compliance with the goals and objectives laid out in the Stimulus bill and HIPAA. At a minimum the MLR definitions should include:

- Investments in health information technology, that are designed to improve health care quality reduce medical errors, reduce health disparities and advance the delivery of patient-centered medical care;

- Internal and external review programs required by state or federal law;

- Quality assurance programs that provide direct member services

- Costs associated with the development and maintenance of networks of centers of excellence or provider excellence networks, direct patient safety programs including formulary management, medical management and drug safety;
Wellness programs and direct consumer education programs;

Quality programs that would qualify a plan for accreditation by either URAC or NCQA in states in which those accreditations are mandated;

Pay-for-quality initiatives intended to provide higher quality of direct care to patients;

Nurse call lines;

Care and case management and disease management programs providing direct benefits to policyholders;

Patient monitoring and wellness programs;

Programs designed to ensure patient safety such as MTM and formulary management, drug interaction and drug safety programs;

Quality research programs designed to influence and educate providers about specific patient care initiatives;

Consumer education programs;

Costs associated with maintaining and developing patient-centered medical homes;

Health risk assessments.

All carriers fund efforts to improve the health and welfare not only of their enrollees, but of the communities they serve through community benefit programs, such as research, community-based health partnerships, direct health coverage for low-income families and grants and technical assistance to community clinics, health departments and public hospitals. Many of these programs directly improve health care quality and should be included in the MLR calculation.

PPACA does not require quality activities to be directly related to an insurer’s enrollees. Section 2718(a) (1) requires insurers’ to report the percentage of their total premium revenue spent “on reimbursement for clinical services provided to enrollees under such coverage.” By contrast, Section (a) (2), requires insurers’ to report “for activities that improve health care quality,” without limitation.

Excluding community benefit from the definition of quality activities will have a disproportionate and unfair impact on certain non-profit health insurers. To maintain a tax-exempt status, federal law requires this category of health insurer to provide direct benefit to the community. Thus, non-profits spend revenue on community benefit in lieu of paying taxes. 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 are required by law. If community benefit expenses are treated as administrative expenses under the MLR regulations, non-profit health insurers are extremely disadvantaged.

Similarly, regulations should not penalize carriers for attempting to curb fraud and waste in the health care delivery system. In fact, company fraud programs protect patients from inappropriate or unnecessary services being performed and the cost of those services being reflected in future premiums. Each year, millions – if not billions – of dollars are spent on fraudulent claims. If fraud could be eliminated, billions more dollars would be available to pay for care. In the Medicare system, it is estimated that over $60 billion annually is wasted on care that is either paid for twice, or has never been provided at all, which is why the federal government has announced stepped up initiatives to combat fraud. It seems incongruous that at the same time, state regulators are developing a system that will not only disincentivize carriers, but will in fact punish them for attempting to do the same thing. We strongly urge the inclusion of all fraud programs in the quality category to recognize that in order to maximize the provision of quality care, carriers must maximize the funding to pay for it.

H. Sales, General and Administrative Expenses; Special Circumstances

We generally agree that reporting for these expenses be in the broad types the draft has set out. Some values for the proposed lines will come fairly directly from contracts that are included in the various columns of the report, such as commissions. Others, however, will differ dramatically from those shown in the expenses exhibits of the annual statements, because the expense exhibit report reflects expenses for the company as a whole, rather than for the limited scope of reporting required by section 2718. Therefore the instructions should allow for a broad range of methodologies to allocate the actual expenses into the various types of expense lines in the supplement and the various columns. The approach used by a carrier should be consistent from year-to-year or changes should be clearly disclosed.

In addition, we note that particularly in the individual and small group markets, carriers in the initial years of a policy will generally experience significantly higher administrative costs due to distribution expenses. Claims experience almost universally increases in the longer durations of a policy, as the policyholders utilize the services and benefits it covers over time. Therefore, should the MLR be applied to each calendar year, individual and small group carriers will effectively be barred from introducing new policies and will be penalized over the next three years, until 2014, for the new policies that have recently been sold. These existing policies have fixed acquisition costs already embedded in them, and the claims experience has not had sufficient time to develop. As pointed out in the letter from the American Academy of Actuaries, this could force some carriers to leave the individual market, and possibly the small group market as well, unless some actions are taken to ensure that their existing structures are taken into account. The subgroup has been tasked by Section 2718 (c) to take into account the special circumstances of smaller plans, different types of plans and newer plans. We urge that these circumstances be taken into account as the methodologies are created and that the early policy year issues for smaller individual insurance and small group insurance writers be given consideration.
Another issue that deserves special discussion involves blanket insurance, such as university student coverage. These cases are typically small and precluded from using current year experience for rating purposes. As a result, good experience cannot be reflected for two years and bad experience cannot be taken into account until the second year after it occurs. This can create a situation where Blanket insurers could face required rebates in certain years and not be able to adjust rates to account for losses in others. We urge the subgroup to take these circumstances into account as well.

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 Randi Reichel at (301) 774.2268 or at reichel01@comcast.net or Bill Weller at (623) 780.0260 or at omegasquared@msn.com.

Sincerely,
Randi Reichel
Bill Weller
May 7, 2010

Lou Felice  
Chair, Health Care Reform Solvency Impact Subgroup, NAIC  
New York State Department of Insurance  
25 Beaver Street  
New York City, NY  10004

Dear Mr. Felice:

I write on behalf of the Council for Affordable Health Insurance (CAHI) to offer comments to assist the NAIC in its very important advisory roll on the joint request for information published by the Department of Health and Human Services, the Department of Treasury and the Department of Labor in the Federal Register on April 14. CAHI offers comments below on what we believe are some critical definitional aspects of the minimum medical loss ratio (MLR) calculations for individual and group coverages.

The Council for Affordable Health Insurance (CAHI) is a national research and advocacy organization devoted to market-based health care reforms that preserve freedom of choice for individuals and encourage a competitive health insurance market. CAHI members include health insurers, physicians, actuaries, agents and small business owners. Our member companies are active in the Medicare supplemental (“Medicare Supplement”), individual, small group, health savings account and senior markets.

Cost Containment as an Important Aspect of Medical Costs

We have serious concerns with the notion that cost containment expenses can reasonably be excluded from medical costs. One of the fundamental reasons to require plans to meet a loss ratio is to ensure that patients receive the highest possible value for their health care dollar. Excluding many cost containment tools from the consideration of either medical claims costs or activities that “improve health care quality” under the new reform law will only harm patients, while removing an important incentive for carriers to spend consumer dollars on health claims in a consistently wise and prudent manner.

For example, several state insurance laws recognize the costs associated with the creation and maintenance of provider networks as a legitimate portion of medical expenses, and not an element of administrative costs. Provider networks have been proven to reduce expenses for both carriers and their customers. More to the point, they offer quality control elements at the clinical level that are otherwise unattainable. For example, in order to qualify for in-network status, providers must complete a rigorous credentialing process ensuring quality care for all network patients.
Other cost containment services – like precertification – help to ensure that patients are receiving medically appropriate, high quality care. These services also save the patient significant out-of-pocket costs. Excluding these activities from medical care is likely, over the long run, to lead to higher medical and insurance costs.

But perhaps the biggest problem with allocating these activities as administrative expenses for purposes of calculating the new minimum MLR requirements is that it creates precisely the wrong incentive. This is because insurers who act appropriately will be both lowering their medical loss ratios and increasing their administrative expenses. This “double hit” could well discourage carriers from effectively controlling medical claims costs, while improving the quality of care received in exchange for those payments.

Therefore, we respectfully ask that you carefully consider retaining some or even all reasonable cost containment related activities – and the costs associated with them – within the purview of medical expenses or improvements in the quality of care.

Improving Patient Care

Given the pace of medical innovation, it is highly likely that the delivery of patient care will change (and hopefully, improve) greatly in the coming years. The pending loss ratio definition is one of the earliest and most important decisions that will be made as part of the federal rulemaking process. We would therefore suggest that the NAIC consider a broad definition of what should be included in medical expenses. This flexibility will help to ensure that patients have a variety of delivery options in the marketplace – from tightly managed HMOs to true indemnity insurers.

Insurers also engage in significant medical management activities, the costs of which may inadvertently be categorized as “administrative.” But they are fundamentally directed at the quality and overall value of the care provided:

- Medical management can prove especially valuable to patients in finding medical providers, and working with patients to evaluate their treatment options;
- Nurse “healthlines” provide patients direct access to qualified nurses and other clinical professionals, and should properly be considered as an integral part of patient care;
- Network credentialing ensures patients are treated by quality medical providers;
- Network-related costs ensure patients have access to a choice of high quality medical providers;
- Collection of HEDIS and other patient quality data ensures patients are receiving high quality care; and
- Transplant network access and contracts with centers of excellence offer significant patient benefits. Many local hospitals rarely, if ever, perform many of the procedures offered through these arrangements, which can offer better clinical outcomes and fewer complications.

Loss Ratios and Their Potential Adverse Impact on Bronze and Silver Plans

We are concerned that the medical loss ratio standards could have an adverse impact on the availability and affordability of plans with lower actuarial value – especially plans that are now actuarially comparable to or will become “bronze” or “silver” plans as those standardized benefit options are brought into the market. The MLR standards would penalize these plans relative to plans with higher actuarial values. This is due to the fact that these benefit plans are often not designed to pay first-dollar claims for routine expenses. As a result, they would not be able to include these claims in the numerator.
as “paid claims.” The issue is that such plans must still process these claims to apply network discounts, member cost-sharing, and appropriate accounting against deductibles and out-of-pocket limits. As a result, the administrative costs associated with these processed but not paid (by the plan) claims are higher as a percentage of premiums collected. This requirement will almost certainly incentivize insurers to offer more expensive plans that allow for higher administrative expenses, while discouraging the marketing of more modestly priced silver and bronze plans. The likely result is a future market dominated by more expensive “gold” and “platinum” plans, adding significantly to the costs of public income-based subsidies provided under the new reform law.

The simple reality is that a number of the administrative costs associated with insurance are relatively fixed. If we assume two individuals with the same claims history, one who purchases a high value plan and one who purchases a lower value plan, the MLR requirements create a perverse incentive which hurts the lower value, lower cost plan. This is because both individuals have the same number of claims, and it costs the same to process each of those claims. It costs the same to provide access to 24 hour, seven-day-a-week customer service on a toll free line. It costs the same to collect the premiums. The fact is that most insurance company costs are relatively fixed.

We would urge the NAIC to incorporate this concern into their input to the federal agencies.

MLRs and Individual Plans

We have serious concerns with the impact of the proposed minimum MLRs on perhaps the most vulnerable and cost conscious segment of the market -- individual health insurance plans. We believe a temporary exemption from these standards is appropriate – at least until the insurance exchanges are fully implemented under the new reform law. This is necessary due to the higher marketing, premium collection, and other expenses associated with most individual insurance plans.

The NAIC standards for individual market loss ratios vary between 55%-65%, depending on the type of plan. In fact, most guaranteed renewable plan loss ratios are set by the states at 60% or less. Even California – a state heavily dominated by managed care and non-profit insurance plans – sets its loss ratio at 70%. Without some relief from the proposed MLR requirements – either by incorporating the benefits of cost containment activities as part of either medical- or quality-related expenses (see above), or a temporary safe harbor for individual market plans – we fear there will ultimately be little room for meaningful competition in all the states, not just the states cited by President Obama in his speech before Congress.

Small Company Issues

We agree with those, including the U.S. Health and Human Services Secretary, who have expressed concerns about preserving the ongoing viability of smaller carriers in the health care marketplace. These companies face unique market and regulatory challenges that should be taken into consideration in the proposed minimum MLR calculations. We would specifically ask you to keep in mind the following:

- Smaller insurers should be exempted from the tighter MLR rules;
- Smaller companies should be given more flexibility in MLR calculations between blocks of business, and in combining blocks of business for MLR purposes; and
- Reinsurance expenses should be considered as a medical expense and not an administrative expense.
It is important to note that health reform implementation will be particularly costly for many of these smaller companies. At least during the implementation period through 2014, the MLR standards should reflect the heavier financial burden borne by small companies and we would urge policymakers to adopt some reasonable accommodations to provide meaningful relief to this important segment of the market.

**Combining Insurance Blocks**

One of the major issues for the federal government going forward is whether or not the individual and small group markets should be combined for the purposes of calculating the minimum MLR standards. We would urge the NAIC to recommend to the federal agencies that carriers be afforded the flexibility to make that determination on a carrier-by-carrier basis.

We greatly appreciate the opportunity to provide input on an issue of significant importance to our members. Please do not hesitate to contact me if you have questions.

Sincerely,

Kevin S. Wrege, Esq., Regional Director of State Affairs

J. P. Wieske, Acting Executive Director

Cc: Richard Diamond, Chair, Actuarial MLR Subgroup  
   Todd Sells, NAIC Staff  
   John Engelhart, NAIC Staff  
   Brain Webb, NAIC Staff
May 7, 2010

Commissioner Jane L. Cline
President
National Association of
Insurance Commissioners
2301 McGee Street
Suite 800
Kansas City, MO 64108-2662

Dear Commissioner Cline:

I am writing to share my thoughts with you about the implementation of the new law establishing minimum medical loss ratios in the commercial health insurance market. I am extremely concerned that the health insurance industry is mounting an all-out effort to weaken this important consumer protection provision included in the health care reform legislation President Obama signed into law in March. I appreciate the complexities you face as you work to implement the medical loss ratio provision over the next few months, but I also urge you to keep in mind the very simple principle underlying this provision – most of consumers’ health insurance premiums dollars should be going to pay for patient care, not for insurers’ administrative costs and profits.

There is no doubt that the health insurance industry has now shifted its focus from opposing health care reform to influencing how the new law will be implemented. The new minimum medical loss provisions, which take effect on January 1, 2011, are currently a focus of the health insurance industry’s lobbying efforts. The authors of an April 27, 2010, Barclays Capital health care market analysis explained the reason for this focus very clearly:

As we have spoken about on numerous occasions, we believe that the definition of Medical Loss Ratios for the purpose of health care reform will be one of the most important events for the year for managed care stocks [bold in original].

While I understand that regulators need to consider the financial implications of this new law for health insurance companies, I also want to remind you (in bold type) that the implementation of these new minimum medical loss ratios will be one of the most important events for consumers and small businesses before health insurance exchanges start operating in 2014.

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1 Joshua R. Raskin, Barclays’ Capital Equity Research, Health Care – Managed Care Industry Overview: First Sign of MLR Language Positive (April 27, 2010).
Letter to Jane L. Cline
May 7, 2010

Data analyzed by the Senate Commerce Committee staff and others show that many insurers already meet the newly established medical loss ratio requirements in the group and individual markets that go into effect next January. But the data also show that in some markets and some product lines, insurers are not yet meeting the new requirements.  The purpose of the legislation is to provide health insurance companies falling below the requirements a new incentive to spend more of every premium dollar on patient care and the quality of that care. To the extent insurers try to invent ways to "game" the minimum medical loss ratio requirement without changing their actual business practices, they are defeating the purpose of the medical loss ratio provision.

Based on media reports and comments that have been filed with the National Association of Insurance Commissioners (NAIC), it is clear that health insurance companies are focusing on two key areas in medical loss ratio implementation: 1) they are proposing that medical loss ratio information be aggregated in a way that conceals important variations in the health insurance market, which would make it easier for insurers to meet the new minimum medical loss ratios of 80% in the individual and small group markets, and 85% in the large group market, and 2) they are eager to classify as many expenses as possible as medical or "quality-improving" expenses, which would also make it easier for them to meet the new minimum medical loss ratios and avoid paying rebates to their policyholders.

In this letter, I will address both of these issues and present health insurance company financial information that I think will assist you in the implementation process. I believe that medical loss ratio information should be aggregated at a level that will be useful for consumers shopping for individual or group coverage in a specific market area. I also believe that health insurance companies must be able to prove that a particular expense actually improves health care quality before insurers can count it as a medical expense.

1. Minimum Medical Loss Ratios Must Be Aggregated and Reported in a Way that Benefits Consumers

For-profit health insurers routinely report company-wide medical loss ratio information to their investors in their quarterly financial reports. For investors, a stable or declining company-wide medical loss ratio means that a company is controlling its costs and is more likely to be profitable in upcoming quarters. For regulators, company-wide medical loss ratios can provide useful information about a company's overall financial condition and its ability to meet its future claims obligations.

As I have pointed out on several occasions, however, medical loss ratios vary widely by insurance product type and by geographic location. As a result of this variation, company-wide

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medical loss ratio information has little or no value for a consumer shopping for health insurance in the individual or group markets.\(^3\)

For example, WellPoint told its investors that, in 2009, its overall commercial medical loss ratio was 82.6%. But as a recent Senate Commerce Committee staff report demonstrated, consumers purchasing WellPoint insurance products in the individual and small group markets experienced medical loss ratios significantly below the company-wide rate (73% and 79%, respectively).\(^4\)

There was not only a great deal of variation between different market segments. There was also great variation within each of the market segments. A table included in the Commerce Committee staff report shows that in 2009, WellPoint customers purchasing individual or small group policies from different WellPoint subsidiaries in different states were subject to widely varying medical loss ratios.

**2009 Medical Loss Ratios for Selected WellPoint Subsidiaries by Market Segment**

<table>
<thead>
<tr>
<th>Subsidiary</th>
<th>Individual Segment</th>
<th>Small Group Segment</th>
<th>Large Group Segment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem Health Plans of NH</td>
<td>62.9%</td>
<td>87.9%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Anthem Health Plans of VA</td>
<td>72.1%</td>
<td>66.6%</td>
<td>79.4%</td>
</tr>
<tr>
<td>Rocky Mountain Hospital &amp; Medical</td>
<td>74.1%</td>
<td>79.9%</td>
<td>83.1%</td>
</tr>
<tr>
<td>Blue Cross Blue Shield of GA</td>
<td>75.5%</td>
<td>78.0%</td>
<td>86.0%</td>
</tr>
<tr>
<td>Anthem Health Plans of KY</td>
<td>79.4%</td>
<td>80.9%</td>
<td>82.0%</td>
</tr>
<tr>
<td>Anthem Health Plans of ME</td>
<td>95.2%</td>
<td>86.9%</td>
<td>89.5%</td>
</tr>
</tbody>
</table>

*Source: 2009 NAIC Accident & Health Policy Exhibit Filings*

For example, WellPoint customers purchasing individual health insurance policies in New Hampshire were subject to a very low medical loss ratio (62.9%), under which WellPoint used more than one-third of its customers’ premium dollars for administration and profits. Across the border in Maine, however, consumers purchasing individual insurance from WellPoint enjoyed a much higher medical loss ratio of 95.2%.

The Commerce Committee staff report also noted similar variations in the small and large group markets. While small employers purchasing group health insurance in Virginia were subject to a medical loss ratio of 66.6%, small business owners in neighboring Kentucky

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\(^3\) See *e.g.*, Letter from Chairman Rockefeller to Mr. H. Edward Hanway, Chairman and CEO of CIGNA (Nov. 2, 2009) (online at: http://commerce.senate.gov/public/index.cfm?p=HearingsandPressReleases&ContentRecord_id=dab514f7-1fe7-496b-a8b8-712987792fa8&ContentType_id=77cb43da-aa94-497d-a73f-5c951f72372&Group_id=165806cd-d931-4605-aa86-7fafa5fd3536&MonthDisplay=11&YearDisplay=2009).

\(^4\) *Supra*, note 2.
experienced a medical loss ratio (80.9%) that already exceeds the minimum loss ratio level set in the health reform law.

This information clearly shows that medical loss ratios significantly vary according to where consumers live and in which market segment they are shopping for health insurance. Aggregating medical loss ratio data at the national or multi-state levels therefore will not capture this diversity of consumer experience and would potentially deprive consumers in states such as New Hampshire or Virginia of the new law’s benefits. For example, aggregating medical loss ratios at high levels would make it difficult for regulators to identify harmed consumers such as the New Hampshire individuals or Virginia small businesses, who are entitled to rebates because they are subject to medical loss ratios that fall below the minimums set in the new law.

Likewise, aggregating medical loss ratio between market segments (such as combining individual and small group medical loss ratios) fails to capture the significant differences between insurance coverage offered in the different market segments.

I therefore recommend that you require insurers to report their medical loss ratio information at a level of aggregation that would allow consumers living in a particular State or other definable geographic region to determine how insurers are spending their health care premium dollars.\(^5\) Aggregating this information at too high a level will present consumers with misleading averages of multiple, disparate markets. For the same reason, I also recommend that insurers provide separate medical loss ratio information for the individual, small and large group market segments.

2. **Insurers Must Demonstrate that their Quality-Improving Expenditures Are Actually Benefiting Consumers**

Health insurance companies and insurance regulators have generally defined the medical loss ratio as the value of the claims an insurer pays in a certain period (“incurred claims”) divided by the total value of the premiums the insurer collects during the period. The medical loss ratio provision in the new health care law makes an important change to this definition by creating a new accounting category for expenditures on “activities that improve health care quality.”\(^6\) These quality-improving expenditures will not be considered as administrative expenses, but as medical expenses that can help insurers attain the new minimum medical loss ratios of 80% in the individual and small group markets, and 85% in the large group market.

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\(^5\) In situations where health insurance companies do not have sufficient premium volumes to develop statistically reliable medical loss ratio data for a particular State, the Secretary and/or State regulators should have the discretion to determine the level of aggregation that will provide credible loss experience for consumers.

\(^6\) Sec. 2718(a)(2) of Title XXVII, Part A of the Public Health Service Act, as added by Sec. 10101(a) of Title X of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010).
Letter to Jane L. Cline
May 7, 2010

This new expense category will give health insurance companies whose insurance products fall below the new federally required minimum medical loss ratios a strong financial incentive to reclassify their existing administrative expenses. For example, under the new law, if an insurer collected $100 million in premiums from business owners for small group coverage, and then used $78 million of these premiums paying claims and $22 million on administrative costs and profits, it would be required to rebate $2 million to its policyholders. But if the insurer found a way to reclassify 2% of its administrative expenses as “quality improvement expenses,” it would then meet the 80% minimum medical loss ratio for small groups, and would be able to keep the $2 million.

The recent Commerce Committee staff report discussed how insurers are actively reviewing their accounting practices and attempting to shift expenses from the administrative to the medical side. For example, WellPoint has already announced it has started “reclassifying” certain expenses it has traditionally classified as administrative, such as nurse hotlines, disease management, and clinical health policy. By reclassifying these expenses as quality-improvement expenses, WellPoint projected its company-wide 2010 medical loss ratio would increase by 1.7%. This “accounting reclassification” means that the company has converted more than a half a billion dollars of 2010 administrative expenses into medical expenses.7

The purpose of the “health care quality improvement” category in the medical loss ratio provision was not to provide health insurance companies new opportunities to cook their books. The purpose of the provision was to encourage health insurers to spend money on health care services that have been demonstrated to improve the safety, timeliness, and effectiveness of patient care. This provision and many other similar provisions included in other titles of the new health care reform law reflect President Obama’s and the Congress’ commitment to improving the quality of health care delivery and ultimately patient health outcomes in the United States.

I appreciate that developing a definition of “activities that improve health care quality” in a period of several months is a difficult task. I also appreciate that insurers are probably bombarding your office with lists of “quality-improving” expenditures they would like you to include in the definition you are currently developing. For these reasons, I recommend that you ground your definition of quality-improving activities in the already existing research on health care quality that the Agency for Healthcare Research and Quality has performed in consultation with non-governmental entities.

If insurers propose that certain types of expenditures, such as “disease management” or “clinical health policy” expenses, be considered quality-improving expenses under the new law, you should require them to substantiate these claims. You should require them to demonstrate that these expenses will improve health care quality, as that term is currently defined and

7 Supra, note 2.
understood by a consensus of the groups that track health care quality indicators and establish health care quality standards.\(^8\)

Once these evidence-based definitions are established, you should also require health insurance companies to consistently apply them to their balance sheets. An insurer should not be able to define an expense as medical one year when it finds itself below the minimum medical loss ratio, but then define it as administrative another year when it is above the minimum. In addition, the definitions should be modified over time as health care quality research provides new information about health care delivery best practices.

As a reference point, you should consider what health insurers are currently spending on so-called “cost containment” expenses. An accounting guidance issued by the NAIC in 2002, known as “SSAP 85,” allows health insurers to subtract certain “cost containment expenses” from their claims adjustment expenses, and thereby reduce their reportable administrative expenses. SSAP 85 defines cost containment expenses as expenses that “serve to reduce the number of health care services or the cost of such services.”\(^9\) Cost containment expenses include spending on activities such as case management, fraud detection, disease management, and smoking cessation programs.

While some of the activities currently defined as cost containment expenses in SSAP 85 should not be included in the definition of “activities that improve health care quality,” health insurers’ actual reported cost containment expenses provide a useful benchmark. While insurers are telling you what they intend to spend on quality improvement in future years, cost containment expense reports show what portion of every premium dollar insurers are currently investing in improving the efficiency of health care delivery.

Cost containment data reported to NAIC and analyzed by the Senate Commerce Committee staff shows that insurers currently invest only a tiny portion of their premium revenues in cost containment activities. Attached to this letter is a table showing the 2009 cost containment expenses of 113 health insurers that exclusively or almost exclusively sold comprehensive health coverage in the fully insured market.\(^10\) This table shows that these companies spent an average of 1.15% of their premium dollars on cost containment activities.

\(^8\) A number of commenters to the NAIC have discussed whether certain preventive health services should be defined as quality-improving expenses. These comments do not appear to have considered another new provision in Title I of the health care reform law (Sec. 2713), which requires insurers to pay the full costs of preventive services that have received high ratings from the U.S. Preventive Services Task Force. This new coverage requirement is likely to have the short-term effect of moderately increasing insurers’ incurred claims expenses and therefore their medical loss ratios.

\(^9\) NAIC, SSAP No. 85: Claims Adjustment Expenses, Amendments to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses (June 10, 2002).

\(^10\) Using NAIC data from the 2009 Health Annual Statement Blank (the “Orange Book”), Committee staff analyzed the cost containment expenses of the 113 health insurance companies writing over 90% of their business in comprehensive major medical, with at least $10 million in earned premiums. The analysis was limited to this group because cost containment expenses are reported on a company-wide, rather than a product-specific, basis. See the table attached to this letter for more information.
Letter to Jane L. Cline
May 7, 2010

For example, the table below shows cost containment data for the 11 UnitedHealth subsidiaries that almost exclusively sold comprehensive health insurance in 2009. All but one of these companies spent less than 1% of their premium dollars on cost containment.

**2009 Cost Containment Expenses by Selected UnitedHealth Subsidiaries**

<table>
<thead>
<tr>
<th>Subsidiary</th>
<th>Premiums Collected</th>
<th>Cost Containment Expenses</th>
<th>% Cost Containment of Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxford Health Insurance Inc</td>
<td>$4,357,890,632</td>
<td>$9,924,656</td>
<td>0.2%</td>
</tr>
<tr>
<td>Optimum Choice Inc</td>
<td>$460,388,489</td>
<td>$2,885,216</td>
<td>0.6%</td>
</tr>
<tr>
<td>Neighborhood Health Partnership Inc</td>
<td>$431,571,309</td>
<td>$2,406,816</td>
<td>0.6%</td>
</tr>
<tr>
<td>UnitedHealthcare of IL Inc</td>
<td>$80,827,326</td>
<td>$445,012</td>
<td>0.6%</td>
</tr>
<tr>
<td>UnitedHealthcare of KY Ltd</td>
<td>$48,995,795</td>
<td>$280,137</td>
<td>0.6%</td>
</tr>
<tr>
<td>UnitedHealthcare of TX Inc</td>
<td>$32,417,101</td>
<td>$161,581</td>
<td>0.5%</td>
</tr>
<tr>
<td>United Healthcare of LA Inc</td>
<td>$29,185,947</td>
<td>$132,112</td>
<td>0.5%</td>
</tr>
<tr>
<td>UnitedHealthcare Ins Co of the River</td>
<td>$68,136,654</td>
<td>$471,191</td>
<td>0.7%</td>
</tr>
<tr>
<td>Health Net Insurance Co NY Inc</td>
<td>$726,780,187</td>
<td>$13,975,695</td>
<td>1.9%</td>
</tr>
<tr>
<td>Mansi Life &amp; Health Ins Co</td>
<td>$120,260,636</td>
<td>$641,177</td>
<td>0.5%</td>
</tr>
<tr>
<td>Pacificare Life Assurance Co</td>
<td>$184,723,354</td>
<td>$1,285,486</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

*Source: NAIC Health ("Orange Book") Filings*

Because insurers have strong financial incentives to “MLR shift” as many expenses as possible from the administrative to medical side, I urge you to review with skepticism any insurance industry proposal that would allow insurers to claim that they will spend significantly higher portions of premium dollars on quality improvement in the year 2011 than they are currently spending on cost containment.

For example, Carl McDonald, an Oppenheimer health care market analyst, recently discussed a scenario in which insurers could shift as much as 500 basis points (or 5%) of premium revenues from administrative to medical.\(^{11}\) Such a shift, which represents a 400% increase over current levels of cost containment spending, clearly suggests insurers are discovering accounting loopholes, rather than actually investing in improving patient care.

**Conclusion**

During the process of implementation of the medical loss ratio provision, I urge you to keep in mind that it was not written to help health insurers’ maximize their profitability over the next three years. The purpose of this provision was to provide consumers in the individual and group markets an assurance that most of their premium dollars would be spent on health care, rather than on administrative costs and profits. I look forward to working with you on this and

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\(^{11}\) Carl McDonald and James Naklicki, Oppenheimer & Co. Inc. Equity Research Industry Update, *The Average Person Thinks He Isn’t – Minimum Medical Loss Ratio Analysis* (Apr. 8, 2010).
Letter to Jane L. Cline  
May 7, 2010  
other important consumer protection issues as the new health care reform law is implemented over the next few years.

Sincerely,

[Signature]
John D. Rockefeller IV  
Chairman

cc:  Kay Bailey Hutchison  
Ranking Member
May 10, 2010

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

Mr. Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

RE: MEDICAL LOSS RATIOS; REQUEST FOR COMMENTS REGARDING SECTION 2718 OF THE PUBLIC HEALTH SERVICE ACT

Dear Messrs. Ostlund and Felice:

The California Department of Managed Health Care (DMHC) appreciates the opportunity to provide the National Association of Insurance Commissioners (NAIC) with California specific information to assist the NAIC in drafting a response to the request for information promulgated by the Department of Health and Human Services (HHS). For ease of reference, the DMHC’s draft responses to HHS’s questions are attached hereto as Appendix 1. (Please note that the attached Appendix 1 represents the DMHC’s preliminary thoughts regarding HHS’s questions; further and more detailed information and analyses will be provided as needed.)

Background

In California, the health insurance market is regulated by two separate agencies—the DMHC and the California Department of Insurance (CDI). The DMHC oversees health services for more than 21 million insured Californians, regulating 108 health care service plans (health plans or plans) and certain preferred provider organization products operating in California. The CDI regulates all other indemnity health products and touches approximately 2.5 million lives covered by CDI-regulated health insurance products. Another approximately 6.8 million lives are covered by Administrative Service Organization products regulated by CDI.
The plans regulated by the DMHC are governed by the California Knox-Keene Health Care Service Plan Act of 1975\(^1\) (Knox-Keene Act or Act) and the regulations thereunder. As discussed in detail in Appendix 1, the Knox-Keene Act does not expressly provide Medical Loss Ratio (MLR) standards or requirements. Rather, plans are prohibited from spending an "excessive amount" of their annual revenue from plan subscribers or enrollees on administrative costs.\(^2\) If, in any given period, the administrative costs of an established plan exceed 15 percent of the revenue obtained by the plan from subscribers and enrollees, the plan may be required by the DMHC to demonstrate that its administrative costs are not "excessive," that the costs are justified under the circumstances, and that the plan has instituted effective procedures to reduce administrative costs. For plans in the developmental phase (generally the first five years), administrative costs should not exceed 25 percent of revenue received from subscribers and enrollees.

Under the Knox-Keene Act, administrative costs include those costs arising out of the operation of the health plan that are not direct, and overhead costs incurred in furnishing health care services. As detailed in Appendix 1, such costs include salaries and benefits for plan employees (other than those who also provide medical care), advertising costs, legal and accounting fees, and all other direct costs incurred in the operation of the plan that are not essential to the actual provision of health care services.

Health plans provide quarterly and annual financial statements to the DMHC in accordance with the Generally Accepted Accounting Principles (GAAP). These statements provide information regarding the plans’ revenues, medical expenses, and administrative expenses. The DMHC also conducts routine medical surveys every three to five years, during which the DMHC examines the plans’ cost allocations.

**Areas Requiring Special Consideration**

In drafting a response to HHS’s request for information, the DMHC urges the NAIC to keep in mind the various types of health plans and the different reporting issues that may exist for the different types of plans, as well as issues relating to how certain costs are categorized.

**Health Information Technology**

As set forth in more detail in the attached Appendix, California’s current state regulation does not expressly include health information technology (HIT) expenditures in the definition of administrative expenses. Accordingly, consideration should be given to how expenditures related to HIT will be classified or apportioned between medical and administrative costs.

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\(^1\) California Health and Safety Code section 1340 et. seq.

\(^2\) California Health and Safety Code section 1378.
Integrated Health Plans

An integrated health plan, such as Kaiser Foundation Health Plan (one of the largest health plans in California), pays relatively few “claims” in the traditional sense, with the health plan, medical groups, and hospitals all functioning interdependently. Because the payment of “claims” is an essential part of the MLR calculation under section 2718, consideration should be given as to determining the appropriate manner for calculating MLR for a plan operating under this unique model.

Delegated Model

California enjoys the benefits of the most robust, delegated, capitated provider group system in the country, managing the health care for approximately seven million HMO enrollees. It is important in any analysis of Medical Loss Ratio to “do no harm” to a system that delivers quality, cost-effective healthcare. It is important to note that, in a delegated model, the plan delegates a certain amount of risk to provider groups or “risk bearing organizations” (RBOs). The capitation payment from the plan to the provider group or RBO includes a certain amount for administrative costs. Thus, the issue of how capitation payments by plans operating under a “delegated model” will be apportioned between medical and administrative costs is of critical importance.

Thank you for this opportunity to provide input regarding the NAIC’s response to HHS’s request for information. Should you have any questions, please do not hesitate to contact Sarah Ream or Gary Baldwin, senior counsels in the DMHC’s Office of Legal Services, at (916) 322-6727 or sream@dmhc.ca.gov and g baldwin@dmhc.ca.gov, respectively.

Sincerely,

[Signature]

Lucinda A. Ehnes, Esq.
Director
California Department of Managed Health Care

SR: sr
Enclosure: Appendix 1
Appendix 1—DMHC’s Draft Response to HHS’s Request for Information

The information set forth below is submitted for purposes of inserting into the multi-state chart being developed by NAIC. For ease of reference, each question from HHS is set forth below in bold, with the DMHC’s respective responses thereto.

Before turning to HHS’s questions, NAIC asked states to confirm whether the AHIP chart of state mandatory medical loss ratio requirements is accurate for their particular states. With respect to the California market regulated by the DMHC, the chart provides accurate information; however, some clarification in the chart indicating that California has two regulators (DMHC and CDI) and that the law differs with respect to the plans and insurers regulated by the two entities, might be helpful.

A. Actual MLR Experience and Minimum MLR Standards

1. How Do Health Insurance Issuers’ Current Medical Loss Ratios for the Individual, Small Group, and Large Group Markets Compare to the Minimum Standards Required in PPACA?

The Knox-Keene Act does not include a “Medical Loss Ratio” standard specifically. Rather, the Act provides that no plan shall expend for administrative costs in any fiscal year an excessive amount of the aggregate dues, fees, and other periodic payments received by the plan for providing health care services to its subscribers or enrollees. Health plans are required to file annual and quarterly financial statements with the DMHC. Based on that information, as well as information obtained during the DMHC’s periodic financial exams of the plans, the DMHC reviews whether plans have “excessive” administrative expenses.

Section 1378 of the Knox-Keene Act requires plans to have administrative expenses totaling no greater than 15 percent of their revenue from subscribers and enrollees. Newer plans that are in the process of becoming established are expected to have administrative expenses no greater than 25 percent of revenue. However, the Act does not provide requirements or limitations regarding how much profit a health plan may earn. In other words “profit” is outside the definition of administrative expense. If a plan’s administrative expenses exceed the percentage allowed under the Act, the plan may be required to demonstrate that its administrative costs are not “excessive,” that the costs are justified under the circumstances, and that the plan has instituted effective procedures to reduce administrative costs.

It may be difficult for some plans to achieve the minimum standard for the small groups and individual markets without substantial changes to their business mix and strategies, including altering cost-sharing amounts and premiums. This is because existing products were not

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3 The Knox-Keene Act does contain minimum MLRs for Medicare supplement contracts, as prescribed by federal law in section 1395, subdivision (i)(1) of title 42 of the United States Code. However, because these MLRs are set by federal law, as opposed to being California specific, they are not addressed specifically in this letter.
designed to meet the new minimum MLR standards contained in section 2718 of the Patient Protection and Affordable Care Act (PPACA).

Additionally, MLR may not be an adequate measurement for plans, like Kaiser, that use an integrated staff model or for plans that use a delegated model. Under a staff model, a plan pays medical costs to affiliated providers, and thereby incurs minimal administrative costs associated with claims payment activities. Accordingly, a staff model may have a larger percentage of expenses counted as medical costs.

2. What factors contribute to annual fluctuations in issuers' medical loss ratios?

General economic conditions such as inflation and unemployment contribute to annual fluctuations in MLR, because inflation can increase the cost of medical services, while unemployment can result in decreased enrollment and plan revenue. The following elements, for example, have also been observed to contribute to MLR fluctuations in some instances:

- Holding premiums constant or raising premiums.
- Increased utilization of services or an outbreak of disease, which increases enrollee utilization.
- Increased prescription costs.
- Increased medical staff salaries, which increase the cost of medical services because increased provider costs are often passed on to the health plans by way of higher capitation rates in future contract negotiations. Also, higher medical costs affect risk-sharing payments.
- Increased software costs.
- Reductions in Medicare Advantage capitation levels or reimbursement on Medicare Part D, as such reductions decrease premium revenue and can result in a higher MLRs.
- Change in the mix of business, because each product line (e.g., large group, small group, individual) offered by a plan typically has different MLRs. Individual products generally have higher MLRs. PPO and HMO products may also have different MLRs. If the mix of business changes, overall MLR for a health plan may also change. In addition, within the same product line, each product has different elements (e.g., different co-pays, deductibles) that can result in different MLRs.
- Changes in accounting for revenue recognition and expenses.

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4 Based on financial information filed with DMHC, the MLRs of the five largest health plans during 2009 ranged from approximately 86.27 percent on average for the four plans that use the delegated model, to as high as 93.51 percent for Kaiser.
b. To what extent do States have different minimum MLR requirements based on plan size, plan type, number of years of operation, or other factors?

The Knox-Keene Act does not set forth specific requirements for MLR.

2. What Criteria Do States and Other Entities Consider When Determining if a Given Minimum MLR Standard Would Potentially Destabilize the Individual Market? What Other Criteria Could Be Considered?

The DMHC knows from its experience that the MLR is an insufficient measure, on its own, with which to evaluate the viability of a plan, except in the extreme cases. Thus, it is an insufficient measure for determining whether market destabilization is likely to result from withdrawal of a plan or product(s).

B. Uniform Definitions and Calculation Methodologies

1. What Definitions and Methodologies Do States and Other Entities Currently Require When Calculating MLR-Related Statistics?

As discussed in section A.1., above, the Knox-Keene Act, which was written when most or all California health plans were not-for-profits, does not specifically contain MLR calculations or statistics, and plans are not required to file their assumptions and methodologies with the DMHC. However, the Act does prohibit “excessive” administrative costs and sets forth expenses that are included in administrative costs.

Administrative costs include “only those costs that arise out of the operation of the plan, excluding direct and overhead costs incurred in the furnishing of health care services, which would be ordinarily incurred in the provision of such services whether or not through a plan.”

Such administrative costs include:

- Salaries, bonuses and benefits paid or incurred with respect to the officers, directors, partners, trustees or other principal management of the Plan, less to the extent that such persons also are providers of health care services, the minimum reasonable cost of obtaining such services from others.

- The cost of soliciting and enrolling subscribers and enrollees, including the solicitation of group contracts, and including any indirect costs of enrollment borne on behalf of the plan by the holder of a group contract.

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5 California Code of Regulations, title 2, section 1300.78, subdivision (a).
• The cost of receiving, processing and paying provider claims and of claims for reimbursement by subscribers and enrollees, excluding the actual amount paid on such claims.

• Legal and accounting fees and expenses.

• The premium on fidelity and surety bonds, and some types of insurance required by law. Malpractice insurance is generally not considered an administrative cost.

• All costs associated with the establishment and maintenance of agreements with providers of health care services, excluding the cost of reviewing quality and utilization of such services, and the cost of reviewing utilization of health care services on a referral basis.

• The direct or pro rata portion of all expenses incurred in the operation of the plan that are not essential to the actual provision of health care services to subscribers and enrollees, including but not limited to office supplies and equipment, clerical services, interest expense, insurance, dues and subscriptions, licenses (other than licenses for medical facilities, equipment or personnel), utilities, telephone, travel, rent, repairs and maintenance, depreciation of facilities and equipment, and charitable or other contributions.⁶

  a. What assumptions and methodologies do issuers use when calculating MLR-related statistics? What are some of the major differences that exist, as well as pros and cons of these various methods?

Medical expenses

As stated above, plans are not required to file their assumptions and methodologies with the DMHC. However, based on industry practice, the DMHC considers certain expenditures to be medical expenses, including the following:

• Disease management, wellness programs, and nurse hotlines.

• The costs of reviewing quality and utilization.

The DMHC also generally classifies “pay-for-performance” payments as medical expenses, because such payments can be viewed as additional payments for the provision of health care services.

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⁶ California Code of Regulations, title 2, section 1300.78, subdivision (a).
Similarly, risk pools are also generally classified as medical expenses; however, the DMHC has seen the payment of pools allocated inconsistently by plans. Consideration should be given to developing specific language defining, or templates laying out, how the pool is calculated and paid. Language may also be needed in the regulations requiring actual payout of the risk pool to be included in the medical loss ratio calculation.

**Administrative expenses**

Common administrative expenses include:

- Transparency initiatives, which the DMHC typically treats as either a marketing expense or contract acquisition expense, which are specifically required by the Knox-Keene Act to be an administrative expense.

- Incentive rewards, such as offering enrollees running shoes or health club memberships, because such awards are typically used to attract or retain members.

- Provider credentialing, network development, and provider contracting expenses, because these costs are generally considered network maintenance costs.

**b. What kinds of assumptions and methodologies do issuers currently use for allocating administrative overhead by product, geographic area, etc.? What are the pros and cons of these various methods?**

In general, health plans in California follow the guidance set forth in the Knox-Keene Act’s implementing regulations and the GAAP, as well as common industry practice, when determining what expenses are administrative.

**c. What kinds of assumptions and methodologies do issuers currently use when calculating the loss adjustment expense (or change in contract reserves)? What are the pros and cons of these various methods?**

Health plans should use an actuarial model or historical experience in determining whether they need to create a reserve for a product that has a lag between the date of service, date of submission, and date of payment. If a plan sells a product for which the plan believes the premium will not cover the cost of the product, the plan should estimate the amount of a premium deficiency reserve.

**d. To what extent do States and other entities receive detailed information about the distribution of non-claims costs by function (for example, claims processing and marketing)? To what extent do they set standards as to which administrative overhead costs may be allocated to processing claims, or providing health improvements?**
Health plans are required to submit to the DMHC compensation amounts, interest expenses, occupancy costs, depreciation and amortization, management fees, marketing costs, affiliate administrative services costs, and other aggregate administrative costs.

The DMHC examines cost allocation in its routine plan examinations, which are conducted every three to five years. The DMHC gathers supporting information to the extent necessary to determine whether the plan’s cost allocations are reasonably accurate on a materiality basis.

Currently, expenses related to claims processing are generally treated as administrative costs. Any type of information systems have been treated as administrative expenses. The costs of information systems are generally capitalized and depreciated over a three-to-five year period for software. However, plans have generally not separated out information systems as either medical or administrative.

e. What kinds of criteria do States and other entities use in determining if a given company has credible experience for purposes of calculating MLR-related statistics?

The Knox-Keene Act does not set forth specific requirements for MLR based upon any of the factors set forth in section B.1.a, above. However, as discussed above, the Act and its implementing regulations provide general guidelines for determining proper allocation of administrative expenses for the purpose of computing administrative cost ratios. The DMHC’s financial examinations and other compliance actions provide references regarding the plans’ abilities to properly allocate medical and administrative costs. Proper allocation of costs has an impact on the plans’ ability to compute their MLRs accurately.

f. What kinds of special considerations, definitions, and methodologies do States and other entities currently use relating to calculating MLR-related statistics for newer plans, smaller plans, different types of plans or coverage?

As discussed above, although current regulations under the Knox-Keene Act do not provide a standard on MLR, they do provide a higher limitation on the administrative cost ratio for a new plan in the development phase (generally, during the plan’s the first five years).

2. What Are the Similarities and Differences Between the Requirements in Section 2718 Compared to Current Practices in States?

Although the Knox-Keene Act does not set forth specific standards for MLR, the Act’s overall goal is the same as that of section 2718 – to limit spending on administrative costs so that more premium dollars are spent on the provision of health care services. Section 2718 provides a comprehensive regulatory tool for computing MLR by product, and provides rebate provisions when minimum MLR is not achieved.
a. What MLR-related data elements that are required by PPACA do issuers currently capture in their financial accounting systems, and how are they defined? What elements are likely to require systems changes in order to be captured?

Health plans currently submit to the DMHC premiums and medical expense information via electronic filings in accordance with GAAP on a quarterly and annual basis. Additionally, plans file revenue and medical expense information with the DMHC by product line (e.g., commercial, Medicare, Medi-Cal).

Although additional levels of aggregation may be needed for PPACA purposes, health plans now have very sophisticated accounting software systems that can drill down to the lowest level of costs (e.g., the hourly rate of a nurse, cost of specific supplies used). Plans have complete and detailed knowledge of what revenues come in and what expenditures go out. However, depending on MLR reporting requirements, health plans may need to modify their systems to report MLR with additional levels of aggregation, such as revenue expenses by type (e.g., individual or group or other aggregation requirements).

b. What MLR-related data elements that are required by PPACA do States or other entities currently require issuers to submit, and how are they defined? What elements are not currently submitted?

Information Currently Submitted By Health Plans

The health plans currently submit revenue and medical expense information via electronic filings on a quarterly basis, and submit premium rate information for certain types of products, such as small group and HIPAA individual coverage. In addition to information provided in their quarterly filings, the plan files revenue and medical expense information by product line (e.g., commercial, Medicare, Medi-Cal). Additional levels of aggregation may be needed for PPACA, such as revenue expenses by type (e.g., individual or group or other aggregation requirements.)

Listed below are revenue and medical expenses items that health plans currently report to the DMHC:

Revenues:

- Premium (Commercial) – Revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time, normally one month. If advance payments are made to the reporting entity for more than one reporting period, the portion of the payment that has not yet been earned is treated as a liability.

- Capitation – Revenue from a HMO or health care service plan as compensation for providing health care services to enrollees of the reporting entity.
• Co-payments, Coordination of Benefits (COB), Subrogation – Revenue recognized by the reporting entity for co-payments, COB, or subrogation.

• Title XVIII - Medicare – Revenue resulting from an arrangement between the reporting entity and the Health Care Financing Administration (HCFA), for services to a Medicare beneficiary. Including revenues for Medicare Cost and Risk contracts.

• Title XIX – Medicaid – Includes revenue resulting from an arrangement between the reporting entity and a Medicaid state agency for services to a Medicaid beneficiary. The reporting entity, for a fee, agrees to cover the full medical costs of Medicaid subscribers. Also includes all other revenues from other governmental and public programs (e.g., Healthy Families, Healthy Kids, AIM, IHSS revenues).

• Fee-For-Service – Revenue that is recognized by the reporting entity for provision of health services to non-enrollees and services provided to enrollees that are excluded from their prepaid benefit packages.

• Point-of-Service Plan Premiums – Revenue recognized by the reporting entity for the provision of health care services to enrollees who are enrolled in a point of service plan.

• Interest – Interest earned from all sources.

• Risk Pool Revenue (for Limited License Plans Only) – Revenue earned from risk-sharing contracts. The reporting entity may have contracts that contain certain shared-risk provisions whereby the reporting entity can earn additional incentive revenue based upon the utilization of services by the reporting entity’s enrollees.

• Aggregate Write-ins for Other Revenue – Revenue from sources not covered in the other revenue accounts, such as recovery of bad debts or gain on the sale of capital assets, etc.

Medical and Hospital Expenses

• Inpatient Services – Capitated – Capitation costs incurred by the reporting entity for the costs of routine and ancillary services to enrollees confined to an acute care hospital.

• Inpatient Services – Per Diem – Per diem costs incurred by the reporting entity for costs of routine and ancillary services to enrollees confined to an acute care hospital. “Per diem” is defined as a flat rate payment for each day of an enrollee’s hospital stay.

• Inpatient Services – Fee-For-Service/Case Rate – Fees incurred by the reporting entity on a fee-for-service basis for the costs of routine and ancillary services to enrollees confined to an acute care hospital.
  o Routine hospital service includes regular room and board (including intensive care units, coronary care units, and other special inpatient hospital units), dietary and nursing services, medical surgical supplies, medical social services, and the use of certain equipment and facilities for which the provider does not customarily make a separate charge.
Ancillary services include laboratory, radiology, drugs, and delivery room and physical therapy services. Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge.

This also includes the cost of skilled nursing and intermediate care facilities. Skilled nursing facilities are primarily engaged in providing skilled nursing care and related services for enrollees who require medical or nursing care or rehabilitation services. Intermediate care facilities are for enrollees who do not require the degree of care and treatment that a hospital or skilled nursing care facility provides, but who do require care and services above the level of room and board.

- Primary Professional Services – Capitated – Capitation costs incurred by the reporting entity to primary care physicians, dentists, or other professionals, for the delivery of medical services. Also included are the costs associated with operating staff model facilities (e.g., salaries, fringe benefits).

- Primary Professional Services – Non-Capitated – Costs incurred by the reporting entity, on a fee-for-service basis, for the delivery of medical services. Includes referrals by capitated providers for which the reporting entity is at risk.

- Other Medical Professional Services – Capitated – Capitated costs incurred by the reporting entity for other medical professional services.

- Other Medical Professional Services – Non-Capitated – Fees incurred by the reporting entity to providers on a fee-for-service basis for other medical professional services.

- Other Medical Professional Services – Compensation, including fringe benefits, paid by the reporting entity to providers engaged in the delivery of medical services and to personnel engaged in activities in direct support of the provision of medical services. This includes dentists, psychologists, optometrists, podiatrists, extenders, nurses, clinical personnel such as ambulance drivers, technicians, paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel, and medical record clerks.

- Non-Contracted Emergency Room and Out-of-Area Expense – Expenses for non-contracted health delivery services including emergency room costs incurred by enrollees for which the reporting entity is responsible. This includes out-of-area service costs for emergency physician and hospital services.

- Point-of Service Plan Out-Of-Network Expenses – Out-of-network expenses that were provided to enrollees in a point-of-service plan.

- Pharmacy Expense - Capitated – Capitated costs incurred by the reporting entity for providing prescription drugs to enrollees.

- Pharmacy Expense – Fee-For-Service – Fees incurred by the reporting entity for providing prescription drugs on a fee-for-service basis.
• Aggregate Write-ins for Other Capitated Medical and Hospital Expenses – Includes the costs directly associated with the delivery of medical services under a reporting entity arrangement which are not appropriately assignable to the medical expense categories defined above (e.g., costs of medical supplies, medical administration expenses, malpractice insurance, etc.).

• Aggregate Write-ins for Other Non-Capitated Medical and Hospital Expenses.

3. What Definitions Currently Exist for Identifying and Defining Activities That Improve Health Care Quality?

The Knox-Keene Act does not specifically list or define activities that improve the quality of health care. The definitions of activities that improve health care quality vary among health plans. There is a trend toward Accountable Care Organizations, in which health plans take more initiative in getting enrollees the care they need.

a. What criteria do States and other entities currently use in identifying activities that improve health care quality?

The DMHC conducts periodic routine and non-routine surveys of the health plans it regulates. During these surveys, the DMHC identifies activities that improve health care quality.

b. What, if any, lists of activities that improve health care quality currently exist? What are the pros and cons associated with including various kinds of activities on these lists (for example, disease management and case management)?

Please see 3. above.

c. To what extent do current calculations of medical loss ratios include the amount spent on improving health care quality? Is there any data available relating to how much this amount is?

The DMHC does not specifically track the amounts plans spend on improving health care quality.

4. What Other Terms or Provisions Require Additional Clarification To Facilitate Implementation and Compliance? What Specific Clarifications Would Be Helpful?

As discussed above in section B.1., the way that risk pools are allocated may need to be more clearly defined. Likewise, consideration should be given to how administrative costs are captured with respect to integrated health plans, such as Kaiser Foundation Health Plan.
Similarly, it may be helpful to have reporting requirements to ensure uniform reporting by risk bearing organizations to the plans they contract with.

C. Level of Aggregation

1. **What Are the Pros and Cons Associated With Using Various Possible Level(s) of Aggregation for Different Contexts Relating to Implementation of the Provisions in Section 2718 (That Is, Submitting Medical Loss Ratio-Related Statistics to the Secretary, Publicly Reporting This Information, Determining if Rebates Are Owed, and Paying Out Rebates)?**

The benefits associated with using the same levels of aggregation in different contexts include uniformity in the information being reported across contexts, making it potentially easier for the public, lawmakers, and others to compare plans and products. However, the level of information required to be reported to the Secretary or used for the purpose of determining and paying rebates may be more detailed than some consumers want or would necessarily understand.

2. **What Are the Pros and Cons Associated With Using Various Possible Geographic Level(s) of Aggregation (e.g., State-Level, National, etc.) for Medical Loss Ratio-Related Statistics in These Same Contexts (i.e., Submitting Medical Loss Ratio-Related Statistics to the Secretary, Publicly Reporting This Information, Determining if Rebates Are Owed, and Paying Out Rebates)?**

Given significant geographic variations in the cost of living (including differences in prevailing wages), it may make sense to use geographic levels of aggregation, such as a state level, to obtain more accurate MLR information. In addition, because many (if not all) states currently require plans to report revenue and expenses at the state level, continued reporting at the state level may make sense.

D. Data Submission and Public Reporting

1. **To what extent do States or other entities currently require annual submission of actual medical loss ratio-related statistics for the individual, small group, and large group markets? How do these current requirements compare with the requirements in PPACA?**

In California, health plans licensed under the Knox-Keene Act submit premium and medical expense information to the DMHC as part of their financial filings via electronic filings on a quarterly and annual basis. From this information, the DMHC is able to determine the percentage of revenue a plan spends on administrative costs.
2. How soon after the end of the plan year do States and other entities typically require issuers to submit the required MLR-related statistics? What are the pros and cons associated with various timeframes?

Plans currently submit premiums and medical expenses information as part of their financial statement filings via electronic filings on a quarterly and annual basis. Annual filings are due 120 days after the end of the plans’ fiscal year; quarterly filings are due 45 days after the close of the quarter. The benefit of using these time frames is that the timeframes are consistent with the plans’ typical audited reports.

3. What kinds of supporting documentation are necessary for interpreting these kinds of statistics? What data elements and format are typically used for submitting this information?

Plans currently submit premium and medical expense information as part of their financial statements filing via electronic filings on a quarterly and annual basis. Currently, the DMHC does not require supporting documentation to accompany these filings; however, the DMHC periodically audits the plans’ filings as part of its financial examination process.

4. What methods do issuers use for purposes of submitting medical loss ratio-related data to these entities (for example, electronic filing and paper filing)?

Plans currently submit premiums and medical expense information to the DMHC as part of their financial statement filings via electronic filings on a quarterly and annual basis.

5. To what extent is MLR-related information submitted to States or other entities currently made available to the public, and how is it made available (for example, level of aggregation, and mechanism for public reporting)? What are the pros and cons associated with these various methods?

Financial information filed by plans is generally available on the DMHC’s website. Information may also be obtained via Public Records Act requests.

6. Are there any industry standards or best practices relating to submission, interpretation, and communication of MLR-related statistics?

Health plans prepare financial information in accordance with GAAP. The American Institute of Certified Public Accountants (AICPA) also publishes the AICPA Audit and Accounting Guide for Health Care Organizations.

7. What, if any, special considerations are needed for non-calendar year plans?

To improve comparability, it is preferable to have the information based on the same reporting period. However, special consideration should be made for governmental plans that are on a fiscal year basis. They would likely need to be reviewed and compared separately from commercial health plans.
E. Rebates

1. To what extent do States and other entities currently require MLR-related rebates for the individual, small group, large group, and/or other insurance markets, and how are these rebates calculated and distributed?

Not currently applicable under state licensing laws to health plans operating in California.

2. How soon after the end of the plan year do States and other entities currently require issuers to determine if rebates are owed?

Not currently applicable under state licensing laws to health plans operating in California.

3. What are the pros and cons of various timeframes and methodologies for calculating rebates?

Not currently applicable under state licensing laws to health plans operating in California.

4. How do States and other entities currently determine which enrollees should receive medical loss ratio-related rebates? What are the pros and cons associated with these approaches?

Not currently applicable under state licensing laws to health plans operating in California.

5. What method(s) do States and other entities currently require issuers to use when notifying enrollees if rebates are owed, and paying the rebates? What are the pros and cons associated with these approaches?

Not currently applicable under state licensing laws to health plans operating in California.

6. Are there any important technical issues that may affect the processes for determining if rebates are owed, and calculating the amount of rebates to be paid to each enrollee?

Not currently applicable under state licensing laws to health plans operating in California.

F. Federal Income Tax

What guidance, if any, is needed for purposes of applying Section 833 of the Code for the first taxable year beginning after December 31, 2009?

No comment at this time.

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7 For example: Current policyholders, current policyholders who were enrolled in the coverage during the applicable time period, or all policyholders who were enrolled in the coverage during the applicable time period (regardless of whether they are still active policyholders).
G. Enforcement

1. What methods do States and other entities currently use in enforcing medical loss ratio-related requirements for the individual, small group, large group, and other insurance markets (for example, oversight and audit requirements)? What other methods could be used?

As discussed above, the DMHC does not have specific MLR-related requirements. However, established plans are expected to have administrative expenses totaling no greater than 15 percent of their revenue from subscribers and enrollees. Newer plans that are in the process of becoming established are expected to have administrative expenses no greater than 25 percent of revenue. If a plan’s administrative expenses exceed that amount, the plan may be required to demonstrate that its administrative costs are not excessive, that the costs are justified under the circumstances, and that the plan has instituted effective procedures to reduce administrative costs.

2. What, if any, penalties do these entities currently apply relating to noncompliance with medical loss ratio-related requirements? What, if any, related appeals processes are currently available to issuers?

Not currently applicable under state licensing laws to health plans operating in California.

H. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

1. What Policies, Procedures, or Practices of Group Health Plans, Health Insurance Issuers, and States May Be Impacted by Section 2718 of the PHS Act?

Depending on the state’s role, if any, in the collection and calculation of data to produce the MLR, the dissemination of medical loss ratio information and enforcement of the medical loss ratio, the DMHC would need to propose changes to the Knox-Keene Act and the regulations thereunder to conform with the additional MLR requirements of section 2718. The DMHC may also need to revise its examination manual, and other tools used by its examiners, to include MLR verification. The DMHC may also need to hire additional staff, including additional examiners, analysts, and actuaries.

a. What direct or indirect costs and benefits would result?

Direct benefits may include preventing unreasonable premium increases, thereby making health care more affordable, as well as ensuring that adequate premium dollars are spent on health care services. In addition, consumers will have more information regarding how a particular plan spends premium dollars, thereby allowing consumers to make better informed choices when making enrollment decisions. Indirect benefits may include increased
employment opportunities for more actuarial, attorney, claims adjuster, and financial examiner positions.

Direct costs may include additional compliance costs for issuers and increased costs for regulators. Indirect costs may include the loss from the market of small plans that are unable to absorb additional costs related to reporting, potentially resulting in a less competitive market.

b. Which stakeholders will be impacted by such benefits and costs?

Stakeholders will likely include HMOs, insurance issuers, regulators, enrollees, employers, providers, and industries.

c. Are these impacts likely to vary by insurance market, plan type, or geographic area?

The most significant impacts will likely be in the individual and small group markets, and in lower income areas that currently have a high uninsured population.

2. Are There Unique Costs and Benefits for Small Entities Subject to Section 2718 of the PHS Act?

a. What special consideration, if any, is needed for these health insurance issuers or plans?

Some small health plans may not be unable to absorb addition compliance costs or meet MLR standards and, as a result, could drop out of the market, resulting in a less competitive market.

b. What costs and benefits have issuers experienced in implementing requirements relating to minimum medical loss ratio standards, reporting and rebates under State insurance laws or otherwise?

Not applicable to the DMHC for the reasons discussed above.

3. Are There Additional Paperwork Burdens Related to Section 2718 of the PHS Act, and, if so, What Estimated Hours and Costs Are Associated With Those Additional Burdens?

The DMHC currently uses an electronic filing system through which plans file annual and quarterly financial statements. Assuming that the required filings associated with compliance with section 2718 do not differ substantially from those already required by the Knox-Keene Act, it is unlikely that there will be significant additional paperwork burdens on health plans.

However, given that provider groups and RBOs will very likely need to report to the plans regarding how capitation payments are allocated, such reporting requirements may require
additional staff at the provider and RBO level. Likewise, the requirements of section 2718 may pose additional staff hours and costs on the regulators.
May 6, 2010

Mr. Steve Ostlund  
Chair, Accident and Health Working Group

Mr. Lou Felice  
Chair, Health Care Reform Solvency Impact Subgroup

By Electronic Mail

Re: Medical Loss Ratios under Public Health Service Act Section 2718

Dear Mr. Ostlund and Mr. Felice:

The Blue Cross Blue Shield Association (BCBSA), which is comprised of the 39 independent Blue Cross and Blue Shield Plans (“Plans”) that provide health coverage to nearly 100 million Americans, would like to offer our comments as the National Association of Insurance Commissioners (NAIC) works to provide recommendations to the Department of Health and Human Services (HHS) on Section 2718 of the Public Health Service Act, dealing with medical loss ratios (MLRs). The entire Blue Cross and Blue Shield system is committed to working with the NAIC, the States, HHS, and other parties to implement the recently-enacted health care reform legislation.

The delivery of health care in our nation has changed tremendously over the years. As the NAIC considers its recommendations on MLRs, we ask that you consider the following three critical recommendations:

1. The role health plans play in driving quality improvements across the health system to transform care delivery by promoting healthy lifestyles, better managing disease and coordinating care, improving patient safety, combating fraud and encouraging more informed decision making by providers and consumers while working to rein in costs;
2. The importance of providing consumers with the ability to easily compare medical and administrative spending among different products and in particular, between staff and capitated-model HMOs and other insurance models. Today many activities that are considered to be administrative expenses for some insurance issuers are included in the medical component for certain HMOs; and

3. The need to strike an appropriate balance in how the MLRs are defined, aggregated and administered to ensure consumers continue to have access to critical programs and activities that help improve their health and quality of care as well as the value of premium dollars.

The Role of Health Plans in Driving Quality

Our Blue Plans have been leaders in the health care community for over 80 years. While in the past health insurers focused primarily on adjudicating claims, today our Plans play a major role in driving quality improvements throughout the care delivery system to improve outcomes and rein-in costs, including reducing inappropriate and sometimes potentially harmful care.

By properly aligning incentives – through disease management and care coordination, pay for quality initiatives, provider and consumer health education activities, prescription drug adherence programs, etc. – health plans can help drive quality improvements and transform care delivery to improve care for consumers.

It is critically important that “activities that improve health quality” be given a clear definition capable of addressing both current and future quality improvement programs. As such, we propose the following definition: “activities in which insurers are engaged, directly or through contractors, a significant purpose of which is to improve, promote, or protect the quality of health care services for their members.”

We also suggest that a non-exhaustive “safe harbor” list of activities for this category be provided. Examples of categories that should be included are:

- **Provider improvement activities** (e.g., pay for quality program costs related to quality measurement and other care coordination and outcome improvements; provider credentialing and network access fees; provider education designed to improve quality; etc.).

- **Patient safety activities** (e.g., drug interaction and adherence monitoring; programs to eliminate hospital acquired infections; activities to combat fraud and abuse; etc.).

- **Member health improvement activities** (e.g., care coordination; case management; consumer education materials; disease management; nurse call lines; wellness programs; etc.).
• **Quality improvement initiatives** (e.g., accreditation and quality reporting costs required for NCQA and URAC accreditation; clinical research related to improving health care quality; etc.).

Following are a few examples of how Blue Plan investments in quality improvement activities are saving lives, improving health and outcomes and returning dollars to care delivery:

**Eliminating Hospital Acquired Infections:** A Plan works with 62 hospitals through a state initiative to provide tools to eliminate hospital acquired infections (HAIs). The Plan has underwritten most of the costs for hospitals to acquire MedMined™ technology to reduce HAIs. The statewide initiative is estimated to have saved 209 lives and $27 million in 2009 by preventing 2,233 HAIs and avoiding 12,819 hospital days. In light of this success, the program is being implemented in three other states.

**Reducing Hospital Readmissions:** A Plan launched a disease management program in 2001 designed to reduce hospital admissions and improve medication compliance for members with congestive heart failure (CHF). The program used educational materials and one-on-one physician coaching and outreach to improve self-management techniques, as well as offered biometric monitoring equipment to high-risk CHF members that allowed them to report on their conditions from home. The coordinated efforts led to a five percent reduction in hospital readmission rates among members with CHF.

**Coordinating Care and Managing Disease:** A Plan is using critical health IT tools while also offering primary care physicians financial incentives to provide comprehensive, coordinated patient care and management of chronic diseases. Pertinent claims data is shared with providers that can tell the physician which of his or her patients have diabetes and which have not had important tests or screenings as part of their recommended care, such as a blood glucose test within the last year. With this information now readily available, physicians are able to reach out to the patient to make sure they are getting the care they need. This program is yielding impressive results: in just one year, compliance rates for HbA1c blood tests (a key health status indicator for patients with diabetes) jumped from 40 percent to over 90 percent.

**Encouraging Employee Wellness:** A Plan has a comprehensive employee wellness program that was the subject of a comprehensive return-on-investment review published in the February 2008 issue of the *Journal of Occupational and Environmental Medicine*. The study found that every dollar invested by the Plan to operate a worksite wellness program resulted in $1.65 in cost savings from avoided health care expenses among participating workers, totaling more than $1.3 million in savings over a four-year period when compared to a control group.
The study demonstrated the value of worksite wellness programs, reinforcing the benefits to employers and employees in terms of improving overall health and generating financial savings.

**Preventing Adverse Drug Events and Lowering Drug Co-Pays:** A Plan is promoting e-prescribing adoption by subsidizing physicians’ adoption costs and incentivizing providers to obtain and use the technology. Approximately 724 adverse drug events have been prevented, resulting in savings of $630,000 from hospitalizations that were prevented. In addition, consumers have saved approximately $800,000 in co-payments on their prescriptions.

**Improving Patient Safety by Combating Fraud and Abuse:** Blue Cross and Blue Shield Plans are committed to doing our part to eliminate healthcare fraud. The 39 Blue companies and our 600 anti-fraud experts teamed with law enforcement to save our 100 million customers nearly $350 million in savings and recoveries in 2008 and potentially reduced inappropriate and sometimes harmful care.

These are just a few of the many Blue initiatives underway to improve quality while reining in costs.

It is also important to point out that today, staff and capitated-model HMOs include many certain expenses, such as nurse hotlines, utilization management and provider credentialing in their medical expenses. For other insurance issuers, these same costs may be considered administrative. Similar expenses for insurers and HMOs should be given consistent reporting treatment, including those expenditures on activities that improve health quality.

While our proposed definition has significant overlap with “cost containment” activities in NAIC Statement of Statutory Accounting No. 85, we do not believe that the two are synonymous. This new category of expenses is unique to the Section 2718, and any future guidance should take into account that Congress created this new category to ensure consumers continue to have access to these important activities that improve health care quality.

In addition, given the evolving role health insurers continue to play in health improvement activities, other activities currently classified as “non-claims costs” need to be examined to determine whether they should be identified as “clinical costs.”

**Enabling Consumers to Compare Spending Among Insurance Issuers**

Consumers must be able to easily and accurately compare medical versus administrative costs across all insurance issuers, including staff and capitated-model HMOs. There are certain ways in which the accounting treatment of these costs differs today. For example, payments to providers for medical services under capitated HMO
arrangements, and provider salaries and facility operating costs under staff model HMO arrangements, include certain administrative costs relating to the adjustment and recording of claims. (e.g., NAIC Annual Statement Instructions (2009), pp. 46-47, Line 9, Hospital/Medical Benefits, and Line 10, Other Professional Services). A failure to account explicitly for these administrative costs would mislead consumers because HMOs would appear to spend a relatively higher percentage on clinical services costs.

MLR reporting requirements must be consistent for all types of insurance issuers. It is also important to note that the formula described in the first sentence of Section 2718(a) that adds incurred claims (or incurred losses) to loss adjustment expenses also has the effect of providing more accurate comparisons between insurers and HMOs.

This is critical for ensuring consumer choice by assuring meaningful comparisons among all insurance models.

Appropriate Administrative Rules and Definitions Critical to Ensuring Consumer Access to Quality Improvement Activities

There are a number of administrative issues that are critical to ensuring consumer value.

MLR reports and rebate calculations should be performed at the state, market segment, and legal entity level, with certain state-approved exceptions. This calculation should be based on where the policy is issued in the group market and where the policy or certificate is issued to the member in the individual market.

State-based measurements are most appropriate for several reasons. First, HHS and the states are permitted under Section 2718 to set MLR requirements that differ from the general standards of 80% in the individual and small group markets and 85% in the large group market as specified in the law under certain circumstances. A national aggregation would be problematic given these state variations. For example, how would the rebate be treated under a national aggregation for an enrollee in a state with a more stringent MLR standard?

Second, state-level approaches make sense since rate review and pooling occur at the state level. Third, national aggregation would force cross-state subsidies under which consumers in State A receive rebates from premiums paid by consumers in State B, even though the experience of the pool in State A alone would not have justified the rebates. It is important to recognize that there are wide regional differences in terms of health care prices and utilization patterns. State aggregation best serves consumers.

Market segment measurements are appropriate in order to be consistent with the language in the Patient Protection and Affordable Care Act (the Act) related to pooling requirements. Consistent with that concept, in states where the individual market and
small group markets are merged into a single market, the measurements should be based on that merged market rather than an artificial break-out of the two.

Lastly, we caution that basing rebates strictly on a policy form or policy type measurement could raise statistical credibility issues due to inadequate sample size and would undermine the pooling requirements of the Act given that some products inevitably subsidize other products in a market segment.

Legal entities under common ownership in a state should be permitted to combine experience for MLR reports and rebates. For example, a parent insurer may have subsidiaries operating under different licenses in the same state due solely to issues relating to state licensure laws (e.g., a separate health maintenance organization (HMO) license was needed in order to be able to offer HMO products). As such, the distinction between licensed entities under common control can be somewhat artificial in practice. Allowing aggregation between legal entities can benefit consumers by encouraging issuers to continue offering products by subsidiaries with small enrollments.

Exceptions to these general aggregation principles may be needed in cases where the size of the enrolled population in a market segment in a state is not actuarially credible. We do not believe an across-the-board exception is warranted. Instead, state regulators should be able to exercise their judgment in allowing exceptions, balancing the desire to promote competition with the need to protect consumers and ensure they receive the benefits of Section 2718.

It is also important that these calculations be based on where the contract is issued in the group market, not where a particular employee lives. Importantly, this issue is not limited to the large group market, as small groups near a state border, such as in Kansas City or New York City, often have employees living in multiple states. In the individual market, the situs should be based on where the policy or certificate is issued to the individual, including individual business issued through a trust or association.

Other Technical, Administrative, and Definitional Recommendations. BCBSA also provides the following technical, administrative, and definitional recommendations that are important to ensure the effective implementation of Section 2718.

- Calendar Year Reporting Period. The MLR measurements should be made on a calendar year basis. This is consistent with NAIC financial reporting requirements, as well as the MLR measurement periods for purposes of determining rebate eligibility under Medicare Supplement policies and group and individual policies in the states that have these requirements today. While Section 2718 refers to “plan year,” we believe that a measurement could be made with respect to the portion of the plan year(s) that falls within the calendar year and still be consistent with the requirements of the statute. Multiple measurements based on policyholders’ plan years (i.e., likely their issuance or renewal dates) would raise statistical credibility issues with respect to sample
size, could be inconsistent with the Act’s pooling requirements, and would be difficult and costly to administer. In addition, a strict plan year measurement would lead to consumers in the same exact product receiving different rebate amounts – or no rebate at all – based solely on having different issuance or renewal dates.

- **Reporting and Rebate Deadlines.** We urge that MLR reports be made due no earlier than June 30 and that rebates be paid by August 31. Given that Section 2718 explicitly refers to “incurred claims,” allowing sufficient time after the end of the calendar year for claims to be submitted and paid will reduce the estimation needed to determine which claims were incurred but are still outstanding. After reports are filed, sufficient time is needed to identify which enrollees are due rebates and in what amounts. By way of example, Medicare Supplement loss ratio refunds are paid a month later – by September 30.

- **Rebate Distribution.** Insurers should be permitted to pay rebates to employers with respect to group policies and the named policyholders with respect to individual policies, and rely upon them for further distribution to employees and family members. This would be the most administratively feasible manner of meeting Section 2718’s requirements that each “enrollee” receive a rebate, if applicable. Similarly, if the individual or employer is currently enrolled, insurers should be allowed to provide rebates in the form of premium credits.

For employer groups, one practical concern is that insurers generally do not know the portion of premiums paid by employers and employees, respectively. As such, insurers would be unable to determine consequences of the rebates for groups and their members under federal tax law and the Employee Retirement Income Security Act. Similarly, for individual coverage, insurers may not know which family members paid for the coverage or whether the family claimed a federal tax subsidy.

Consideration also should be given to a “de minimis” rule in the case of small rebate amounts, similar to what is used in Medicare supplement (0.5% of total premium), in which case rebates could be applied to future premiums. This would ensure that the cost of administering rebates is not greater than the rebates themselves.

- **Federal and State Taxes and Licensing or Regulatory Fees.** “Federal and state taxes and licensing or regulatory fees” under Section 2718 should be given a broad meaning consistent with the statute’s plain language, which places few limits on the phrase. Use of this term is intended to ensure more consistent MLR reporting between insurers given their varying federal and state tax obligations and reflects the involuntary nature of these expenses. If the blank is used to administer the rebates, it should be modified to reflect this broad definition in the health reform law.
Current examples of state-level taxes and fees include premium taxes, income taxes, franchise taxes, real and personal property taxes, use taxes, sales taxes, and other regulatory and licensing fees and assessments such as high risk pool assessments, guarantee fund assessments and assessments to fund other private market segments. Many insurers are subject to federal income taxes, and all insurers pay employer payroll taxes. In the future, insurer assessments and taxes will increase because of provisions in the PPACA that will require insurers to help fund Exchanges, including a new tax on insurance beginning in 2014 (which taxes coverage offered by an income tax-exempt HMO at a rate lower than coverage offered by other insurers), excise taxes on high-cost plans, and comparative effectiveness research fees.

- **Federal Employees Health Benefit Program (FEHBP) as Large Group Market Coverage.** As noted in our April 27, 2010, letter, FEHBP coverage is large group market within the scope of Section 2718 and should be treated as such for purposes of MLR reporting and rebates. 29 U.S.C. 1002(1); 42 U.S.C. §§ 300gg-91(a)(1), (b)(1), (4).

Lastly, we note that Section 2718 will give rise to many novel questions concerning the interaction of federal and state MLR requirements. Timely guidance from the federal government and the states will be essential to ensuring insurers are able to understand their obligations and implement the new provision appropriately. Specifically, insurers will need guidance on implementing Section 2718 where its requirements appear to conflict with state law and whether requirements prove to be so extensive that it displaces similar state law requirements entirely.

* * *

Thank you for the opportunity to comment on PHSA Section 2718. We look forward to continuing to work with you on this issue.

Sincerely,

Joan Gardner
Executive Director, State Services
PPACA Implementation:
Consumer Recommendations for Regulators and Lawmakers
May, 2010

Contributors:

Elizabeth Abbott, Health Access
Amy Bach, Esq. United Policyholders
Deelia Beck, Esq. Office of Public Insurance Counsel/Texas
Brendan M. Bridgeland, Esq. Center for Insurance Research
Bonnie Burns, California Health Advocates
Kimberly Calder, National Multiple Sclerosis Society
Sabrina Corlette, Esq. National Partnership for Women & Families
Brenda J. Cude, University of Georgia
Joseph P. Ditré, Esq., Consumers for Affordable Health Care
Stephen Finan, American Cancer Society
Timothy Stoltzfus Jost, Washington and Lee University School of Law

Sonja Larkin-Thorne
Kevin Lucia, Esq. Georgetown University Health Policy Institute
Georgia J. Maheras, Esq., Health Care For All
Stacey Pogue, Center for Public Policy Priorities
Wendell Potter, Center for Media and Democracy
Lynn Quincy, Consumers Union
Barbara Rea, Equality State Policy Center
Mark Alan Schoeberl, American Heart Association
Naomi P. Senkeeto, American Diabetes Association
Barbara Yondorf, Colorado Consumer Health Initiative
Contributors

Elizabeth Abbott  
Project Director  
Health Access  
1127 11th Street, Suite 234  
Sacramento, CA 95814  
Office: 916-497-0923 x 201  
Fax: 916-497-0921  
eabbott@health-access.org

Amy Bach  
Executive Director  
United Policyholders  
222 Columbus Avenue #412  
San Francisco, CA 94133  
Office: 415-393-9990  
Fax: 415-677-4170  
amy@uphelp.org

Deelia Beck  
Public Council  
Office of Public Insurance Counsel/Texas  
333 Guadalupe, Suite 3-120  
Austin, TX 78701-3942  
Office: 512-322-4144  
Fax: 512-322-4148  
dbeck@opic.state.tx.us

Brendan M. Bridgeland  
Director  
Center for Insurance Research  
1130 Massachusetts Avenue  
Cambridge, MA 02138-5204  
Office: 617-441-2900  
Fax: 617-441-6363  
Insuranceresearch@comcast.net

Bonnie Burns  
Training and Policy Specialist  
California Health Advocates  
53080 Elvas Avenue  
Sacramento, CA 95819  
Office: 916-231-5510  
bburns@cahealthadvocates.org

Kimberly Calder, MPS  
Director, Insurance Initiatives  
National Multiple Sclerosis Society  
733 Third Avenue, 3rd Floor  
New York, NY 10017  
Direct: 212-476-0450  
Kim.Calder@nmss.org

Sabrina Corlette  
Director, Health Policy Programs  
National Partnership for Women & Families  
1875 Connecticut Avenue, NW, Suite 650  
Washington, DC 20009  
Office: 202-986-2600  
Fax: 202-986-2539  
scorlette@nationalpartnership.org

Brenda J. Cude  
Professor  
University of Georgia  
215 Dawson Hall  
Athens, GA 30602  
Office: 706-542-4857  
Fax: 706-583-0313  
bcude@uga.edu

Joseph P. Ditre  
Executive Director  
Consumers for Affordable Health Care  
12 Church Street  
P.O. Box 2490  
Augusta, ME 04338-2490  
Office: 207-622-7083  
Fax: 207-622-7077  
jditre@maineachc.org

Stephen Finan  
American Cancer Society, Cancer Action Network  
sfinan@cancer.org  
Tel. 202-661-5780

Timothy Stoltzfus Jost  
Professor  
Washington and Lee University  
School of Law, Lewis Hall, East Denny Circle  
Lexington, VA 22802  
Office: 540-458-8510  
Fax: 540-458-8488  
jost@wlu.edu

Sonja L. Larkin-Thorne  
Consumer Advocate  
5 Avondale Drive  
Avon, CT 06001  
Office: 860-673-6004  
Fax: 860-673-1407  
larkin-thorne@sbcglobal.net

Kevin Lucia  
Assistant Research Professor  
Georgetown University Health Policy Institute  
3300 Whitehaven Street, Suite 5000  
Washington, DC 20007  
Office: 202-784-3136  
Fax: 202-687-3110  
kwil@georgetown.edu

Georgia Maheras  
Private Market Policy Manager  
Health Care For All  
30 Winter Street, Suite 1004  
Boston, MA 02066  
Office: 617-275-2922  
Fax: 617-451-5838  
gmaheras@hcftama.org

Stacey Pogue  
Senior Policy Analyst  
Center for Public Policy Priorities  
900 Lydia Street  
Austin, TX 78751  
Office: 512-320-0222 x 117  
Fax: 512-320-0227  
pogue@cppp.org

Wendell B. Potter  
Senior Fellow on Health Care  
Center for Media and Democracy  
531 Montrose Street  
Philadelphia, PA 19147  
Office: 267-226-4801  
Fax: 267-318-7525  
wendell@prwatch.org

Lynn Quincy  
Senior Policy Analyst  
Consumers Union  
Office: (202) 462-6262, ext. 1125  
lquincy@consumer.org

Barbara Rea  
Senior Policy Analyst  
Equality State Policy Center  
Direct: 307-472-5393  
brea@equalitystate.org

Mark Alan Schoeberl  
Executive Vice President, Advocacy  
American Heart Association  
7722 Greenville Avenue  
Dallas, Texas 75231-4596  
Tel: 214-706-1299  
Mobile: 214-684-1283  
Fax: 214-373-3461  
email: mark.schoeberl@heart.org

Naomi P. Senkeeto, MA  
Associate Director, Policy and Strategic Alliances  
American Diabetes Association  
Office: 703.299.5528  
Mobile: 703.606.7985  
nsenkeeto@diabetes.org

Barbara Yondorf  
President  
Colorado Consumer Health Initiative  
2211 Clermont Street  
Denver, CO 80207  
Office: 303-329-7912  
Fax: 303-839-1263  
yondorf@usa.net
These materials were prepared to assist regulators, lawmakers, and the National Association of Insurance Commissioners during the initial phase of the Patient Protection and Affordable Care Act of 2010, (PPACA). Their purpose is to convey the perspectives of policyholder/consumer advocates on appropriate standards and guidelines for implementing PPACA.

The enclosed issue briefs were drafted and/or reviewed by teams of professionals who are currently serving as funded and unfunded consumer representatives at the National Association of Insurance Consumers. The specific recommendations contained in the materials were not presented to the organizations with which the drafters are affiliated for formal endorsement. Therefore, organizational affiliations are listed for identification purposes only. The authors thank and acknowledge NAIC members and staff, as well as the following individuals for their assistance and contributions to the enclosed materials:

Eliza Bangit, Senior Researcher, Georgetown University
Birny Birnbaum, Center for Economic Justice
Claire Borelli, American Diabetes Association
Sally Duran, The American Heart Association
Harvey S. Frey, MD PhD Esq., Health Administration Responsibility Project
Katie Horton, George Washington University
Carole Johnson, George Washington University
Andy Kurz, former CFO of Blue Cross of Wisconsin
Jenny Libster, Georgetown University
Sarah Lueck, Center on Budget and Policy Priorities
Sally McCarty, Former Indiana Insurance Commissioner
Kathy Mitchell, Consumers Union
Stephanie Mohl, American Heart Association
Sue Nelson, American Heart Association
Edwin Park, Center of Budget and Policy Priorities
Erin Reidy, American Cancer Society Cancer Action Network
Steven Taffet, Taffet Law, P.C.
Dr. Nancy Turnbull, Harvard School of Public Health
Randall S. Udelman, DeFusco & Udelman, P.L.C.

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Section 1003 of the Patient Protection and Affordable Care Act (PPACA) amends §2794 of the Public Health Service Act. Section 1003 requires the Secretary of the Department of Health and Human Services (HHS), in conjunction with the States, to establish an annual premium review process. It requires health insurance issuers to disclose and justify an unreasonable premium increase prior to implementation of the increase. It requires issuers to post justification for the increase on the issuer’s website. The Secretary must ensure public disclosure of information on such increases and justifications for all health insurance issuers. Section 1003 of the PPACA makes $250,000,000 in grants available to States. The grants are for States to review premium increases during fiscal years 2010 through 2014. The Secretary is required to establish a formula for allocating the grants. No state that qualifies for a grant will receive less than $1,000,000 or more than $5,000,000 for a grant year.

**Background**

Section 1003 of the PPACA amends § 2794 the Public Health Service Act (42 U.S.C. 300gg - 91 et seq.). Section 1003 became effective on the date of enactment of the PPACA.

**Section 1003** of PPACA is entitled “Ensuring That Consumers Get Value for their Dollars.” It establishes an initial and a continuing premium review process. It requires the Secretary of HHS, in conjunction with the States, to establish a process for the annual review of unreasonable increases in premiums for health insurance coverage beginning with the 2010 plan year.

Health insurance issuers must submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Health insurance issuers must disclose and justify an unreasonable premium increase prior to implementation of the increase. Health insurance issuers must post justification for the increase on the issuer’s website. The Secretary must ensure public disclosure of information on such increases and justifications for all health insurance issuers.

Section 1003 of the PPACA makes $250,000,000 in grants available to States. The grants are for States to review premium increases during fiscal years 2010 through 2014. To qualify for a grant, a State, through its Insurance Commissioner, must provide the Secretary with “trends in premium increases in health insurance coverage in premium rating areas in the State.” The State must also “make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from the Exchange based on a pattern or practice of excessive or unjustified premium increases.” The Secretary is required to establish a formula for allocating the grants. No state that qualifies for a grant will receive less than $1,000,000 or more than $5,000,000 for a grant year.

In plan years beginning in 2014, the Secretary, in conjunction with the States, must monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.
In determining whether to offer qualified health plans in the large group market through an Exchange, the State must take into consideration any excess of premium growth outside of the Exchange as compared to the rate of growth inside the exchange.

**Principles That Should be Used to Create Standards**

Individual consumers are the ultimate payers of all health care - and health coverage - costs. Even workers in large businesses, whose employer contributes 100% of the insurance premium for the employee, understand that their wages are reduced to reflect the cost of health coverage offered through their employer. Moreover, state courts readily recognize many insurance contracts as contracts of adhesion. In essence, courts recognize the imbalance of economic power between an individual insured and an insurance company. To address this imbalance of power and to create fairness, accountability, and affordability in the setting of insurance rates, consumers, whether individual policyholders or certificate holders in group plans, are entitled to the following:

- A regulatory review process for rate filings that places the interest of policyholders and certificate holders first and foremost;
- A fair and thorough regulatory review process that is conducted before a rate filing can be implemented;
- A regulatory review process that is accessible to the public, provides opportunities for affected policyholders and certificate-holders to participate, and includes public comment periods during which policyholders and certificate-holders can attend on an after-business hours or weekend basis in various geographic locations where large numbers of policyholders and certificate-holders live;
- Sufficient advance notice of a rate filing to enable policyholders and certificate holders to meaningfully prepare for and participate in rate review process;
- Access to all of the information filed by the health insurance issuer in a rate filing including all accompanying documentation;
- A standard of review that determines not only whether a rate filing is “reasonable” but also “necessary;”
- A regulatory process in which the regulator has the authority to require health insurance issuers to refund or return premiums in excess of medical loss ratios set;
- A regulatory process in which the regulator can consider factors such as profitability and surplus/reserves across lines of business in making a determination as to whether a rate filing is “unreasonable;” and
- A regulatory process in which the regulatory agency has the resources necessary to competently and aggressively review and evaluate the assumptions and justifications for the filing.

**Recommendations**

In order to ensure fairness, affordability, and accountability, we believe that the NAIC should create and adopt a national standard of rate review that at a bare minimum, include:

1) authority of insurance departments to review proposed rate filings and authority to approve or disapprove them before they go into effect;
2) a definition of “rate filing” that includes new and renewed premium rates, any proposed rating formula, classification of risks, or modification of any formula or classification of risks;
3) a standard of review that places the burden of proof on the health insurance issuer to demonstrate that the proposed rate filing is not unreasonable, unnecessary, inadequate, or unfairly discriminatory;
4) a standard of review that establishes specific criteria that the health insurance issuer must meet before approval can be granted;
5) a standard of review that establishes additional factors that the commissioner should consider when making a determination as to whether filed rates are “reasonable;”
6) a process that requires the health insurance issuer which fails to meet an established medical loss ratio to refund excess premium collected to policyholders and certificate-holders;
7) transparency in the rate filing process that make all filings and all accompanying documentation public record, thereby removing the trade secret and other exceptions to disclosure;

8) sufficient advance notice to policyholders and certificate-holders to enable them to participate in or comment on rate filing processes; insurance departments should provide a well-publicized and meaningful process for consumers to participate in and provide input into rate reviews and hearings; insurance departments conducting rate reviews should offer consumers after business hours or weekend hearings for public comment sessions;

9) a process that requires the health insurance issuer to post their rate filing to their website;

10) a process that requires the department of insurance to post to its public website information about the rate filing and justification in easy to understand language for the public;

11) a process that allows the commissioner, the state Attorney General, or an affected policyholder or certificate holder to request a hearing be conducted in the rate filing; and,

12) increased capacity within insurance departments to meaningfully and adequately review rate filings employing competent actuaries, economists, and consultants.

### Individual and small group market rate review standards

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<th>Purpose</th>
<th>Proposed Model Act Language</th>
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<tr>
<td>Notice to Policyholders and Certificate-holders</td>
<td>Provides policyholders and certificate holders with advance notice of a rate request in order to have adequate time to budget for increase, gather information about alternative benefit options, provide information to insurance department regarding rate request, participate in rate hearing or approval process, or change insurer.</td>
<td>Every insurer offering individual and small group health plans as defined in section XXXX must provide written notice by first class mail of a rate filing to all affected policyholders and certificate holders at least 90 days but no earlier than 120 days before the effective date of any proposed increase in premium rates or any proposed rating formula, classification of risks, modification of any formula or classification of risks. The notice must also inform policyholders and certificate holders of their right to request a hearing pursuant to section XXXX and any scheduled public hearing dates or public comment opportunities. The notice must state the proposed rate, proposed effective date, and state that the rate is subject to regulatory approval. The superintendent [commissioner] may not take action on a rate filing until 30 days after the notice is mailed and may not take final action until 60 days after the notice is mailed by an insurer. An increase in premium rates may not be implemented until 90 days after the notice is provided or until the effective date under section XXXX, whichever is later.</td>
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<tr>
<td>Rate Filing Requirements</td>
<td>Defines what the insurer must file, in what format, when, and with whom. Provides for the superintendent [commissioner] to suspend the filing period for compliance reasons.</td>
<td>Every insurer shall file for approval with the superintendent [commissioner] every rate, rating formula, classification of risks and every modification of any formula or classification that it proposes to use in connection with individual health insurance and small group policies [and certain group policies specified in section XXXX]. If the filing applies to individual or small group health plans as defined in section XXXX, the insurer shall simultaneously file a copy with the Attorney General. Every such filing must state the proposed effective date of the filing. Every such filing must be made not less than 90 days in advance of the proposed effective date, unless the 90-day requirement is waived by the superintendent, and the effective date may be suspended by the superintendent for a period of time not to exceed 30 days. In the case of a filing that meets the criteria in subsection XX, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the organization satisfactorily responds to any reasonable discovery requests. A filing required under this section must be made electronically in a format required by the superintendent unless exempted by rule adopted by the superintendent. Rules adopted pursuant to this subsection are routine technical rules as defined in [State APA Statute].</td>
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<tr>
<td>Rate Filings Are Public Records</td>
<td>Provides transparency and disclosure to policyholders and the public.</td>
<td>A filing and all supporting information, except for protected health information required to be kept confidential by state or federal statute are public records notwithstanding Title XXX, Chapter XXX, subsection XXX [specific provision(s) in the state Freedom of Information Act, e.g., trade secret or information not subject to court discovery] and become part of the official record of any hearing held pursuant to section XXXX. When a filing is not accompanied by the information upon which the insurer supports such filing, or the superintendent does not have sufficient information to determine whether such filing meets the requirements that rates not be unreasonable, unnecessary, inadequate, or unfairly discriminatory, the superintendent shall require the insurer to furnish the information upon which it supports the filing. The insurance department shall publish the rate filing on its website and include an explanation of the rate filing, the basis for the rate filing, and terms used in the rate filing in easy to understand language that will provide the public with information that they need in order to comment on or participate in the rate review process.</td>
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<tr>
<td>Standard of Review</td>
<td>Defines legal standard that insurer must meet in order to receive regulatory approval of its rate filing.</td>
<td>In any filing or in any hearing conducted under this [chapter of the insurance code], the insurer has the burden of proving that rates are not unreasonable, unnecessary, inadequate, or unfairly discriminatory.</td>
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<td>Right to Hearing; Superintendent/ Commissioner Order</td>
<td>Provides affected policyholders, affected certificate-holders, superintendent, or Attorney General with right to request a hearing.</td>
<td>If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be unreasonable, unnecessary, inadequate, unfairly discriminatory or that the filing violates any of the provisions of this [chapter of the insurance code], the superintendent shall cause a hearing to be held. If a filing proposes an increase in rates in an individual or small group health plan as defined in section XXXX, the superintendent shall cause a hearing to be held at the request of the Attorney General. If the superintendent does not cause a hearing to be held at his or her request or if the Attorney General does not request a hearing, any affected policyholder or certificate-holder. Where an affected policyholder or certificate-holder requests a hearing be held, the superintendent shall hold such hearing. Hearings held under this section must conform to the procedural requirements set forth in Title XXX, chapter XXX, subchapter XXX [adjudicatory provision of the state’s Administrative Procedures Act]. In any hearing conducted under this section, the insurer has the burden of proving rates are not unreasonable, unnecessary, inadequate, or unfairly discriminatory and in compliance the provisions of this chapter [of the insurance code]. The superintendent shall issue an order or decision within 30 days after the close of the hearing or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not to exceed an additional 90 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall establish the date on which the filing is no longer effective, specify the filing the superintendent would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision.</td>
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<td>80% MLR Requirement; Policyholder and Certificate-Holder Refund</td>
<td>Establishes an 80% MLR for the coverage period; excludes quality improvement, wellness programs, and cost containment measures from inclusion in the loss ratio calculation;</td>
<td>Rates subject to this subsection must be filed for approval by the superintendent. The superintendent shall disapprove any premium rates filed by any insurer, whether initial or revised, for an individual health plan [and certain group policies specified in section XXX] or small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under each of the individual health plans or each of the small group health plans maintained in force by the insurer for the period for which coverage is to be provided will return to policyholders and certificate-holders at least 80% of the aggregate premiums collected for those policies or such higher amount as may be set under state law, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. Medical loss ratios shall be calculated separately for each small group and for each individual health plan. For the purposes of this calculation, expenses of or related to wellness programs or cost containment must not be included in the calculation. If incurred claims were less than 80% of aggregate earned premiums during the period for which coverage is to be provided, the insurer shall refund a percentage of the premium to the current in-force policyholders. The excess premium is the amount of premium above that amount necessary to achieve an 80% loss ratio for each of the insurer’s individual health plans during the period of coverage. The refund must be distributed to policyholders and certificate-holders in an amount reasonably calculated to correspond to the aggregate experience of all policyholders and certificate-holders holding policies or certificates having similar benefits. The total of all refunds must equal the excess premiums. The superintendent may require further support for the unpaid claims estimate and may require refunds to be recalculated if the estimate is found to be unreasonably large or not in compliance with the calculation requirements of this [section]. The superintendent may adopt rules setting forth appropriate methodologies regarding medical loss ratio factors, reports, refunds and credibility standards pursuant to this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title XXX, chapter XXX, subchapter XXX [the state’s APA].</td>
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| Standards Before Approval Can Be Granted; Additional Factors For Consideration | Sets standards that must be met before the superintendent can grant approval. Allows superintendent to take into consideration various additional factors in approving or disapproving a rate filing. | Standard for approval. The following standards apply to the making and use of rates pursuant to this section.  
A. Rates are determined not to be reasonable and necessary if the rates are likely to produce a profit from business in this State that is unreasonably high in relation to the benefits provided, the surplus requirements and the surplus available, or if expenses are unreasonably high in relation to the benefits provided.  
B. Rates are determined not to be reasonable and necessary if the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums when replenishment is attributable to investment losses.  
C. Rates are determined to be inadequate if the rates are clearly insufficient, together with investment income attributable to the rates, to sustain projected losses and expenses for the benefits provided.  
D. Rates are determined to be unfairly discriminatory if price differentials fail to equitably reflect the differences in expected losses and expenses or the rates fail to clearly and equitably reflect consideration of the policyholder’s participation in a wellness program or clinically accepted course of preventive care. |

Factors to be considered. In determining whether the standards in subsection XXX [Standard for approval] have been met, the factors considered by the superintendent may include but are not limited to:  
A. The past and prospective net underwriting gains of the insurer from the line of insurance for which the insurer seeks rate approval and from all of its lines of insurance;  
B. The past, current and reasonably expected surplus levels of the carrier anticipated in the filing;  
C. Investment income reasonably expected by the carrier from premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves;  
D. The degree of competition in the market for which the rate approval is sought and in the overall health insurance market;  
E. The degree to which testimony offered by the carrier in support of the components of its requested rates is supported by written evidence such as analyses, reports or studies; and  
F. The profit and risk charge included in the previous year’s rate filing and the profit actually achieved.  
G. Historical and projected administrative costs, and the reasonableness of administrative expenses;  
H. Reasonableness of executive compensation;  
I. Anticipated change in the number of enrollees by rate class if the proposed premium is approved; |
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<td></td>
<td>J. Affordability and equity of the premium structure, given community needs and the insurer’s mission;</td>
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<td></td>
<td>K. Profitability, surplus, reserves, and investment earnings of the issuer over time; rates should be set at the minimum level necessary to ensure solvency, contribute to affordability, maintain rate stability, and deliver quality care.</td>
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<td>L. Changes in covered benefits and plan design;</td>
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<td></td>
<td>M. The insurer’s health care cost containment and quality improvement efforts, and their results.</td>
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<tr>
<td>Blocks of Business</td>
<td>Prohibits health insurance issuers from closing blocks of business to meet rating or other requirements</td>
<td>1) No block of business shall be closed by a health plan unless (1) the plan permits an enrollee to receive health care services from any block of business that is not closed and which provides comparable benefits, services, and terms, with no additional underwriting requirement, or (2) the plan pools the experience of the closed block of business with all appropriate blocks of business that are not closed for the purpose of determining the premium rate of any plan contract within the closed block, with no rate penalty or surcharge beyond that which reflects the experience of the combined pool. (2) A block of business shall be presumed closed if either of the following is applicable: (a) There has been an overall reduction in that block of 12 percent in the number of in force plan contracts for a period of 12 months. (b) That block has less than 1,000 enrollees in this state. This presumption shall not apply to a block of business initiated within the previous 24 months, but notification of that block shall be provided to the director pursuant to subdivision (c).</td>
</tr>
<tr>
<td>Insurance Department Capacity</td>
<td>Funds available to cover the costs of actuaries, financial analysts, economists, or other experts to assist superintendent/commissioner to review and determine whether rates meet state standards or to act as expert witnesses in rate hearings.</td>
<td></td>
</tr>
<tr>
<td>Consumer Participation in rate hearings</td>
<td>To ensure balanced rate review proceedings</td>
<td>Consumer Participation. (a) Any person who intervenes in any proceeding permitted or established pursuant to this chapter, may challenge any action of the commissioner under this [section or provision], and enforce any provision of this article. (b) The commissioner or a court shall award reasonable advocacy and witness fees and expenses to any person who demonstrates that (1) the person represents the interests of consumers, and, (2) that he or she has made a substantial contribution to the adoption of any order, regulation or decision by the commissioner or a court. Where such advocacy occurs in response to a rate application, the award shall be paid by the applicant.</td>
</tr>
</tbody>
</table>
Grants for Ombudsman Programs
Section 2793 of the Public Health Act, as amended by Section 1003 of the Patient Protection and Affordable Care Act (PPACA) calls for HHS to provide grants to states to establish and operate independent offices of health insurance consumer assistance or health insurance ombudsman programs. Consumer advocacy groups whole heartedly support this program and want to ensure the offices have the independence, resources and authority and are organized to best serve the interests of consumers.

Background
The PPACA makes $30 million in the first fiscal year for health insurance consumer assistance or health insurance ombudsman programs, with additional funding for later years. These programs, which we refer to as ombudsman programs for the purposes of this brief, are to:

- Assist with the filing of complaints and appeals;
- Collect, track, and quantify problems and inquiries;
- Educate consumers on their rights and responsibilities;
- Assist consumers with enrollment in plans; and
- Resolve problems with obtaining subsidies.

As a condition of receiving a grant, a state must collect and report to HHS data on the types of problems and inquiries encountered by consumers. The data shall be used to identify areas where enforcement action is necessary and shall be shared with state insurance regulators, the Secretary of Labor and the Secretary of Treasury.

Principles For Allocating Grant Funds
Grant dollars should be allocated to fund high-quality programs and reach consumers with the greatest need.

Characteristics of a “good” ombudsman/consumer assistance program include:

- Projects completed or in process that document their skill at policy advocacy, intervention on behalf of consumers, or successful outreach or educational efforts.
- Prepared to assist consumers who have limited English proficiency, low health literacy, and/or limitations that make it difficult for them to make informed health care choices.
- Demonstrates their independence as a consumer assistance organization by submission of documentation regarding their mission as primarily serving consumers. The bill requires that the ombudsman operate an independent office. Ombudsman programs must be independent so they can assist consumers in filing appeals and focus on the consumer’s side of the case.
• Protects the consumers’ confidentiality, yet includes mechanisms to access the data needed to resolve the consumers’ problems.1 To that end, the program should have or establish good working relationships, with relevant state agencies including the health insurance regulatory agencies. Ombudsman programs should also secure provider/insurer cooperation working within the patient privacy protections afforded by HIPAA.2 Finally, it is critically important that ombudsman programs coordinate with insurance departments to address violations of state insurance laws.3

• Regularly reports to legislators and the public, so policymakers benefit from the valuable and timely information about problems consumers face in the health care system. Data collection and reporting is key to systemic change. Quarterly aggregated consumer data should specify plan names and patient gender, age, location and condition. This data should inform consumers and purchasers of health care regarding the number, content, and resolution of inquiry and complaints. This data should be readily accessible to the public.

• Ensures that consumers get information about the Ombudsman program at the points they most need such assistance. For example, plans should notify consumers of the availability of these programs on coverage determination notices.

• Is adequately staffed and has the resources to competently and efficiently assist consumers with a wide range of grievances and other substantive tasks. Staff training must include detailed knowledge of state and federal laws regarding health insurance and group health plans. Staff knowledge must also include capacity to help resolve consumer problems with obtaining subsidies.

Problems That Consumers Might Encounter
The new grant funds won’t help consumers unless they are aware of these resources. Unfortunately, many consumers don’t know about the assistance resources available to them today. For example, no participant in a 2006 Consumers Union focus group was aware of the state health insurance resources available to them.4

Consumers should not have to struggle to determine regulatory jurisdiction if they have a complaint. States should avoid having the consumer be batted back and forth between the ombudsman office and insurance department. Ideally, the state will establish a “no wrong door” policy and insurance department staff and the consumer assistance department will work seamlessly and cooperatively to ensure the consumer receives the correct services.

Consumers need a coherent system of for tracking complaints and letting them influence policy. Today’s multiplicity of agencies involved in oversight of health insurance plans makes it difficult to develop a comprehensive picture of how well insurance plans are performing on consumer complaints.5 Many other federal, state and private agencies are also involved in oversight of health insurance plans or complaints management. There is no system or universal model of health insurance complaints management across these states and federal agencies.6

Recommendations
Grants to the states must be conditioned on meeting specified standards that ensure the goals of the program are realized, maximum benefit for consumers is obtained, and maximum value for tax payer dollars achieved. To that end, we recommend that priority be given to grant applicants that:

Demonstrate a Broad Ability to Help Consumers
• Grant applicants should be empowered to direct people to coverage, take and respond to complaints, and advocate with regulators, health plan internal appeals panels, and external reviewers on consumers’ behalf.

• Have access to relevant data collected at relevant state agencies (e.g., complaints lodged with state attorneys general or the insurance department). In addition, ombudsmen need strong working relationships with staff in the other relevant agencies.

• Grant applicants should explain their plans for tracking complaints, which can be complex, including whether it seeks to aggregate complaints data from other agencies. Some complaints may be filed directly with the state regulatory agency, others may go to the insurance company directly and be resolved/not resolved there, others may go to a private attorney in the case of an individual who wants to sue.

• Grant applicants should demonstrate an intention and capacity to analyze and publicly report consumer complaint data they receive (in addition to forwarding it to HHS), in an effort to proactively assist consumers. For example,
a pattern of similar complaints might indicate that the office should contact the insurer being cited or issue a consumer advisory. Grant applicants should demonstrate a willingness to use their casework to aid in state and local policy development.\(^7\)

- In their consumer education efforts, grant applicants should indicate they will proactively identify the type of information that is most useful to consumers. These consumer materials should be appealing, use plain language, be written in the languages of state residents, and be understandable by those with lower literacy levels.\(^8\) Applicants should use a variety of methods to “push” this information out to consumers so it is available when they need it (for example, at the point where they are purchasing an insurance policy or at the doctor’s office). Educational efforts that rely on consumers to visit the website on their own initiative are insufficient.

- Grant applicants should document the independence of the ombudsman program they propose to fund. Independence can be enhanced through legislative authority and dedicated funding.\(^9\) If the applicant part of a state agency, documentation should specify all relevant reporting lines. If a free-standing non-profit, this documentation should also include governance structure, organizational funding, and board composition (which should be free from conflicts of interest involving plans, providers and pharmaceutical and device manufacturers). The ombudsman office should have no other programmatic responsibility than to assist consumers with complaints and educate them as to their insurance coverage options as set forth in the Patient Protection and Affordable Care Act.\(^10\)

### Demonstrate Easy Consumer Access

- Grant applicants should demonstrate the myriad ways in which they will make consumers aware of their office and services. For example: including a toll-free number staffed during hours that go beyond 9-5 weekdays; perhaps social media such as Facebook; coalitions with state organizations and agencies who educate and assist health care consumers, and a welcoming physical and online presence (institutional look/government look can be off-putting; some people who need help may deeply distrust the government).

- A state law should require health plans to provide, in all consumer-facing materials, contact information for the office.

- Grant applicants should designate a central entry point for health insurance consumer complaints with referrals to other agencies as relevant. If state responsibility for insurance products is split across several agencies, this should be invisible to the consumer.\(^11\) They should state their intent to establish a cooperative relationship with other relevant agencies and consumer groups and provide transfers to the correct agency/consumer help organization if the consumer problem is beyond their mandate.

### Demonstrate Ability and Willingness to Contribute to a National Knowledge Bank of Consumer Experiences

- Applicants should demonstrate they will track and analyze complaints by health status, age, race, ethnicity, language, geographic location and gender\(^12\) in order to identify any problems that particular populations are facing, and make timely and regular reports of this information to the public.

- HHS should work with programs to establish a simple, standardized reporting format and common definitions of terms (such as what constitutes a complaint).\(^13\) HHS, after public comment, should determine what common data elements should be reported the first year, and then further enhance data reporting in future years as grants continue. They should also use the standard insurance/medical terms required as part of PHSA Section 2717. Report to the federal government on how they are spending the grant dollars, and make this report publicly available.

It makes sense that ombudsman program duties be construed as broadly as possible, allowing flexibility for varying needs among the states. At minimum, ombudsman offices should serve as a portal for consumers to complain about plan behavior in enrollment and appeal handling, and consumer access to subsidies; and as an information source to help consumers understand public and private insurance options, supplementing what the State Exchanges may provide.\(^14\) Prior to soliciting grant applications, HHS should clarify the following with respect to the scope of their duties:

- Are the ombudsman programs expected to help with complaints filed with insurers or also with complaints filed with the insurance department (e.g., in a case where the consumer didn’t get a satisfactory response from the company or what about a complaint about the insurance department itself)?

- Will insurance departments refer consumers with complaints to the ombudsman offices and/or vice versa?

- Are ombudsman programs responsible for helping consumers enrolled in ERISA plans?
• Are ombudsman programs responsible for helping eligible small employers obtain tax credits as well as helping individuals to get subsidies? If not, who is?

As a condition of getting a grant, PPACA requires that states collect and report data on the types of problems encountered by consumers, as well as other types of inquiries. We recommend that HHS take their own steps to maximize the utility of the information being reported by grantees:

• HHS should standardize the reporting format and establish common definitions of terms (such as what constitutes a complaint). For example, HHS may want to distinguish between: complaints where the insurance company is not at fault compared to those where it is at fault. HHS may also want to track at what stage the issue was resolved (e.g., whether it required a formal internal appeal or was resolved through the external appeals process with a third party) and the number of days to resolution. Further, HHS should work with programs to determine what categories of complaints are useful to track. For example, in addition to tracking complaints and appeals regarding denials by diagnoses (a common data element in many states), HHS may want to track complaints about pre-existing condition exclusions, rate-ups, benefit limitations, etc. The use of standardized reporting format and common definitions of terms will allow the agency, states, and consumer advocates to effectively assess trends and respond to issues across states and regions. These standard terms should also be consistent with the standard insurance/medical terms required as part of PHSA Section 2717.

• HHS should develop a strategy for incorporating consumer complaint data from non-grantee states and the other federal and private agencies that receive complaints about health insurance (such as the SHIP offices for seniors or DOL for ERISA plans). HHS must move toward a coherent system for analyzing health insurance complaints management across the states and federal agencies so we have a truly comprehensive picture of how well insurance plans are performing from the perspective of the consumer.

• HHS should use the information provided by states to help guide the necessary standards and rules for the reforms scheduled to take effect in 2014. The information also should be available to researchers under the HIPAA constraints for health services research.

Finally, we recommend that HHS provide resources to help ensure the success of the grantees and the wise use of tax payer dollars:

• States that do not currently have this capability may be reluctant to apply. HHS should encourage them to do so, and help arrange for mentoring by states or non-profit organizations that already have strong, centralized consumer health insurance assistance programs.

• Provide an easy-to-use summary of best practices (commission one if necessary), and a list of experts to provide just-in-time assistance, as necessary.

• Require grantees to document their successes and failures, in such a way that helps future grantees and contributes to an accessible, usable store of knowledge.

• HHS should require and fund annual face to face training events and develop materials by consultation with grantees. HHS could use the services of an outside entity [nonprofit organization] that has experience with consumer assistance to provide this type of back-up support.

We encourage you to look at programs such as Connecticut’s Office of the Healthcare Advocate and the consumer assistance programs run by Health Care for All in Massachusetts (the HelpLine), The Health Consumer Alliance in California, and the Community Service Society of New York as proven models of providing consumers with assistance on health insurance issues.
END NOTES

1 Protecting the consumers confidentiality, while still bringing the maximum resources to bear to help the consumer, is tricky proposition. Insurers will try to get out of talking to anyone except the insured or the commissioner’s office. Also, the ombudsman may need access to records that the insurance company has and may not want to share.

2 To clarify, HIPAA applies to providers and health plans, not to state agencies except insofar as they are business partners. Usually, programs have HIPAA-compliant authorization forms that let them talk to insurers. States have to enter into business partner arrangements if they do this with a nonprofit so that they can share info (regarding Medicaid eligibility, for example) easily and in a HIPAA-compliant way.

3 Insurance departments have traditionally seen themselves as responsible for closely related tasks such as assisting with filing complaints (in the technical sense, not substantive appeals write-ups), collecting, tracking and quantifying problems and inquiries, and educating consumers on their rights and responsibilities. In many cases, insurance departments administer an external appeals system for state-licensed plans.


5 These include the U.S. Department of Labor, the federal Centers for Medicare and Medicaid Services (CMS), state Medicaid agencies, the federally funded SHIP program providing counseling and assistance to seniors on health insurance and many private assistance programs targeting condition-specific populations.

6 [website URL]

7 The Sacramento-based Center for Health Care Rights, part of the Health Consumer Alliance in California, is a strong example of using casework to drive policy advocacy. For example, the Center for Health Care Rights is particularly active in using information derived from its consumer hotline to undertake what it calls “evidence-based advocacy”. Hence the Center publishes policy reports with concrete recommendations directed at health plans, providers, policymakers and regulators on reforms necessary to improve the health system. See: [website URL]

8 A criteria could be adapted from a recent CA law, (SB 853): “These materials should be written in any language shown to represent the language spoken at home by at least 5% of the state’s population or corresponds to the specific required languages for communication with the highest percentages of consumers enrolled in public programs in the state (Medicaid, food stamps, general assistance, TANF etc.). All written communication should be in readable san serif fonts that exceed the minimum font size standard reflected in academic research, currently 12-point font or larger. Interpretation services should be available for a consumer based on their request by utilizing multi-lingual staff, video medial interpretation technology, telephonic language assistance lines, or other language assistance technology that becomes available in the future. Educational efforts and consumer counseling should available not only in multiple languages corresponding to the languages spoken/read in the state, but also available via TTY lines for the hearing impaired or in Braille or by recording for the visually impaired.”

9 For example, the Vermont Health Care Ombudsman has legislative protection “to speak on behalf of consumers…without being subject to any retaliatory action”. The Vermont Health Care Ombudsman also has funding guaranteed under a contract, in contrast to the absence of funding in the authorizing legislation for the ombudsman program in Texas. See: [website URL]

10 The act allows for the Secretary to award grants to exchanges to establish, expand or provide support for an office of consumer assistance. Generally, we recommend against exchanges establishing their own ombudsman programs that are in addition to the independent office serving other consumers, although there may be configurations where this could work smoothly if there are very clear lines of reporting.

11 In 2000, in at least three states (California, Maryland and New York), responsibility for indemnity health insurance and HMOs is split across two government agencies.

12 We recognize that collecting some of this information may be difficult, as it may be off-putting to the person requiring assistance. They may, for example, resist questions about their age and ethnicity, wondering what this has to do with their insurance complaint. If the ombudsman program can get address and zip code information (which most people don’t resist supplying) then the program can at least say this person lives in an area whose population is predominantly low-income and African American.

13 Colorado can provide an example. Consistent reporting across states would also be valuable to insurance departments doing market conduct exams.

14 SHIPs now play this latter role with respect to Medicare and Medigap and may be a good model.
Grandfathered Plans
Patient Protection and Affordable Care Act (PPACA) “grandfathers” health plans in existence on the date of enactment, exempting them from many insurance market reforms. The Consumer Representatives to NAIC strongly support the market reforms and consumer protections required under PPACA. We recommend setting reasonable, well defined limits on a health plan’s ability to maintain grandfathered status through federal regulation to ensure that the law fulfills its promise for the maximum number of patients and consumers. Our recommendations include:

- Ensuring that any change to coverage in a grandfathered health plan results in the loss of grandfathered status;
- Granting an exception that allows a plan to make changes while maintaining grandfathered only for plan changes that benefit all enrollees;
- Applying limits to grandfathering equally to all fully insured and self-insured plans; to active employee and retiree plans; and both before and after full reform take effect in 2014; and
- Requiring that plan sponsors annually notify enrollees of a plan’s grandfathered status and explain reform provisions that do not apply.

Background and Discussion
Section 1251 of the Patient Protection and Affordable Care Act (PPACA) “grandfathers” health plans in existence as of the date of enactment, March 23, 2010. Grandfathered plans are exempt from many insurance market reforms and benefits, with the exception of a few specific reforms enumerated in PPACA and the Health Care Education Reconciliation Act of 2010 (HCERA). Current enrollees may renew grandfathered coverage, new employees may enroll, and dependents can be added without a plan losing grandfathered status. Otherwise, PPACA is silent on whether grandfathered plans can make changes without having to come into compliance with all reform provisions, creating a need for regulatory guidance on the scope of exceptions for grandfathered plans.

Allowing grandfathered plans to avoid compliance with many reforms that apply to new plans creates several issues for consumers.

- Grandfathering is a loophole in the promise of health reform that could prevent many consumers from fully benefiting from increased consumer protections and standards. The table on page 2 lists key provisions of the health reform law that do and do not apply to grandfathered plans.
- Most consumers are covered through an employer, and regardless of their wishes, are not free to choose whether that employer coverage will remain in a grandfathered plan or move to a plan that contains improvements made through health reform.
Insurers and health plan sponsors may look for ways to use the two different sets of rules created by grandfathering to their advantage, to the detriment of consumers. For example, insurers may attempt to segment “good” and “bad” risks between grandfathered and new plans, resulting in higher costs for older and less healthy enrollees. Incentives for health plans to game the system may be especially pronounced in retiree health plans, a major concern for early retirees who are not yet eligible for Medicare.

Grandfathering will create confusion for consumers. Because some health reform provisions apply to grandfathered plans while others do not, it will be difficult for consumers to determine whether their policy has or should have new rights and benefits. This complexity may make it harder for consumers to get accurate assistance when needed from employers, brokers, and regulators.

Grandfathering requires federal and state regulators to operate a dual regulatory system with different rules for grandfathered and new plans, resulting in the need for more aggressive oversight to protect consumers.
Consumer Principles Related to Grandfathered Plans

- Federal and state regulators should protect consumers by setting reasonable, well-defined limits on a health plan's ability to maintain grandfathered status.
- These state and federal rules should anticipate and mitigate opportunities for health plans to exploit differing rules that apply to grandfathered and new plans, to the detriment of consumers.
- Consumers should be able to easily identify whether their coverage is grandfathered or not and clearly understand the benefits and protections not included in grandfathered coverage.

Recommendations

- Federal regulators should ensure that any change to coverage in a grandfathered health plan, other than changes explicitly required by PPACA and HCERA, results in the loss of grandfathered status. For example, benefit changes not required by law, cost sharing increases, and wellness program modifications should terminate a plan's grandfathered status.
- An exception that allows a plan to make changes while maintaining grandfathered status should be made only for plan changes that benefit all enrollees. Federal regulators must create a clear and rigorous standard of what changes constitute a benefit to all enrollees that is not open to manipulation. It must:
  - Count as improvements only changes that leave no individual enrollee worse off,
  - Not rely on changes in plan actuarial value to determine a plan improvement (such changes can mask cost-sharing changes that benefit certain types of enrollees but leave others worse off), and
  - Not use a concept of "net benefit improvement", i.e. allowing some benefit improvements to offset other reductions.
- Limits on grandfathering should apply equally to all fully insured and self-insured plans; to active employee and retiree plans; and both before and after full reform take effect in 2014.
- U.S. Department of Health and Human Services regulations should clarify that it is not the intent of the law that new individuals can enroll after March 23, 2010 in grandfathered plans—except for the clear exceptions specified in the Act (e.g., only for family members of individuals in grandfathered plans (sec. 1251(b)) and new employees in group plans and their dependents (sec. 1251(c)). Fully insured health plans approved by state regulators and marketed before enactment that are sold as of March 24, 2010 to new enrollees (not renewals) to anyone but the individuals excepted above, should be considered a new plan, one which does not have grandfathered status.
- Federal and state regulators should require plan sponsors of grandfathered plans to annually disclose the plan's grandfathered status to enrollees with an explanation of what health reform benefits do not apply because of the plan's grandfathered status.
- States regulators should close any remaining loopholes by reforming state laws applicable to grandfathered plans so that they meet federal standards for new plans. The NAIC should adopt model laws that assist states with this effort.

NAIC Consumer Representatives Grandfathered Plans Workgroup:
Sabrina Corlette, National Partnership for Women & Families
Stephen Finan, American Cancer Society Cancer Action Network
Sonja Larkin-Thorne, Consumer Advocate
Stacey Pogue, Center for Public Policy Priorities
Lynn Quincy, Consumers Union
Immediate Consumer Disclosure Standards
The Patient Protection and Affordable Care Act (PPACA) calls on HHS, with help from the NAIC, to develop a uniform insurance disclosure form. The goal of this form is to help consumers understand and compare health insurance policies including cost-sharing and covered benefits. These new requirements are a tremendous gain for consumers, who typically struggle to understand the provisions of their policies. In this draft, we provide recommendations designed to ensure that these new insurance disclosures are appealing, readily understandable, meaningful and helpful to consumers.

Background
There are three related provisions in PPACA that must be kept in mind when designing disclosures: Section 1103, Section 2715, and Section 2715A. Each of these provisions has a different deadline, the first being May 22, 2010.

Section 1103 of PPACA calls for HHS to create a “mechanism” (including a website) to display current insurance options available in a state, not later than 60 days after enactment (or May 22, 2010). The Act calls for the Secretary to develop a standard format to be used in presenting information relating to coverage options, which shall include:
• The percentage of total premiums spent on non-clinical costs;
• Eligibility (for public coverage programs);
• Plan availability;
• Premium rates; and
• Cost sharing.

The Act requires this information to be consistent with the uniform explanation of coverage as provided for in Section 2715.

Section 2715 of the Public Health Act, as amended by PPACA, calls for HHS to develop a uniform explanation of coverage 12 months from the date of enactment (or by March 23, 2011). These standards will apply to all health plans. This 4-page disclosure form will feature (among other things):
• Standardized medical/insurance terms; and
• A coverage facts label, displaying cost-sharing associated with common benefit scenarios.

Section 2715A further calls for all plans to submit to the Secretary and State insurance commissioner, and make available to the public, the following information in plain language:
• Claims payment policies and practices;
• Periodic financial disclosures;
• Data on enrollment;
Data on disenrollment;
Data on the number of claims that are denied;
Data on rating practices;
Information on cost-sharing/payments with respect to out-of-network coverage;
Other information as determined appropriate by the Secretary.

This requirement starts six months after enactment, or September 23, 2010.

These three provisions are closely related and should be considered together. Collectively, we will refer to them as insurance disclosures. The first task, which we will call the web portal, will be extremely challenging. It must be implemented on an exceedingly tight timeframe. Furthermore, the HHS standards used to display insurance information would ideally be the same as the uniform disclosure standards to be developed in the months following the May 22 deadline.

**Principles That Should be Used to Create Standards**
All insurance disclosures must be readily understandable, meaningful and helpful to consumers, as determined by focus group testing and usability studies. These disclosures must also be visually appealing, increasing the likelihood they will actually be used by consumers.

Briefly, the features that make hard copy documents more appealing and useful include:
- plain-language headings;
- a typeface and type size that are easy to read (the law calls for 12-point type);
- wide margins and ample line spacing;
- boldface or italics for key words; and
- a distinctive type style and graphic devices, such as shading.

When such documentation moves to the Web, myriad other features can greatly increase appeal and usability of the information (over and above the formatting considerations above). For example:
- Ability to customize their view of the material (“I’m a young adult” or “Hablo Espanol”), including building custom plan comparisons;
- Provide definitions via text “roll-overs”;
- The ability to “drill down” when additional information is desired via hyperlinks to new pages; and
- Ability to increase text size for easier reading.

To make the disclosures meaningful, the first page of information should include the information most desired by consumers. The limited research in this area indicates that consumers most want to know 1) whether or not a given provider participates in the plan; 2) potential out-of-pocket costs under common medical scenarios; and 3) their premium cost. Consumers also want a summary measure, developed by a trusted source, that quickly tells them whether or not this is a “good” plan. Because research in this area is limited, and focus group testing minimal, we strongly urge more consumer research and usability testing.

Disclosures must be linguistically appropriate and culturally sensitive.

Finally, and most importantly, disclosures must provide real protection for consumers. Disclosures should help avoid these situations:
- A 2008 Consumer Reports article described a health insurance policy in which hospitalization coverage excluded the first day of hospitalization (in the fine print) – usually the most expensive day when lab and surgical suite costs are incurred.
- Similarly, a detailed comparative study of health plans in Massachusetts and California found that plans with seemingly similar provisions would have left policyholders with out-of-pocket obligations that differed by thousands of dollars. For example, a typical course of breast cancer treatment would end up costing nearly $4,000 in one plan but $38,000 in the other plan—despite the fact the plans contained similar deductibles, co-pays and out-of-pocket limits.
Problems That Consumers Might Encounter
HHS must take very seriously the goal of ensuring that the new disclosures actually help consumers. Numerous studies have documented the failure of mandated disclosures in many consumer areas, such as consumer credit. These mandated disclosure rules often fail to effectively inform consumers, to improve their decisions, or to change the behavior of the relevant institutions. The fail because ordinary people don’t read them, cannot understand them, do not know what to do with the information, and face way too many such disclosures in their every day lives.

In fact, too much mandatory disclosure may even be harmful by desensitizing consumers to warnings that may be helpful.

Designing a disclosure document that is both useful and protects consumers will be very challenging in today’s environment. Prior to the 2014 reforms, consumers will continue to encounter extensive variation in health plan designs. A simple, usable form simply cannot capture all the important policy detail. Consumers may be reduced to “reading the fine print” — reducing the chances that they will understand the policy to near zero. HHS must look for tools and techniques that help consumers meaningfully compare these disparate plan designs.

We are also concerned about managing consumers’ expectations with respect to the web portals scheduled to come online May 22. Due to this rapid deployment, and the fact that the mandated information is not yet standardized, initial versions are likely to be somewhat limited. Consumers’ expectations must be carefully managed so that they are not permanently turned off from using the web portal, just because they initially find limited information there. We expect, given enough time, HHS will be able to put significant improvements in place, leveraging the best ideas from the many excellent examples around the country of “one-stop-shopping” for coverage.

Recommendations
Disclosure form design and side-by-side comparisons are key areas where consumer and patient groups can work closely with NAIC and HHS to ensure that the new standards meet the needs of consumers. To that end, we recommend the following immediate actions.

Analyze consumer needs and preferences. HHS should immediately convene focus groups, and a review of current health insurance disclosures to determine what pieces of information and layout styles consumers find most helpful. This testing needs to be unbiased and account for the needs of a wide variety of consumers, including those with low literacy or low English language proficiency, as required by the law. We also recommend HHS consult with enrollment counselors and patient/consumer advocacy groups in the development phase, as well as for a review of the final prototypes. These groups have a background of working with patients and consumers, and may be able to jump start the search for effective standards. HHS should make the results of this focus group/usability testing publicly available.

Design a summary measure that quickly tells consumers whether or not this is a “good” plan. We recognize the complexity and subjectivity inherent in this task. We encourage HHS to persevere, perhaps using an iterative process, such as starting with summary measures for sub-set of measures. The quality “stars” adopted for Medicare Advantage plans are an example of a summary measure that looks at one component of a plan’s overall performance. This iterative process should feature a strong feedback loop so consumers can report how well they are served by the measures. Early work in the area will help inform the 2014 exchanges, who are tasked with rating health plans. HHS/NAIC may want to identify a “trusted source” to make this determination, increasing the likelihood that consumers will trust the result.

Assess whether or not a variety of disclosure forms might be needed, reflecting the wide variety of consumer needs. This approach might help overcome language/cultural differences, differences in the preferences of younger/older consumers and other areas where preferences vary.

Commit to an ongoing evaluation of the usability of these forms. Identify ways to include a variety of feedback mechanisms so that the usefulness of the forms can be assessed and improved over time. HHS may want to consider leveraging approaches like those used by Yelp or Amazon, where consumers share their own feedback among themselves, to see how well consumers are being served and which types of information are of greatest interest to consumers. This should not serve as the sole feedback mechanism but may provide a useful complement to other methods and be appreciated by consumers.
Consider the “media” of the disclosures for example, as a) paper products, b) online, c) as part of an enrollment counselor’s “tool set.” Anticipate that different media may call for different disclosure designs, but incorporate as much uniformity as possible. Uniformity will help consumers “learn” to use the disclosures and embed them more deeply into their shopping practices.12

Consider how these disclosures will dovetail with other “consumer-facing” reporting requirements in the Act. Again, widespread uniformity at every point will help consumers “learn” to use the disclosures. To that end:

• Develop and test the standalone insurance disclosure (as called for in Section 2715) first, using an aggressive timetable and well in advance of the March 23, 2011 deadline.
• Use this tested standard to build out the comparative “side-by-side” insurance information (as called for in Section 1103 and eventually through the exchanges—Section 1311).
• In building the standalone insurance disclosure, consider how it will interact with other reporting requirements in the law such as:
  – The new quality reporting requirement (section 2717 of PHSA);
  – The new MLR reporting requirement (section 2718(a) of PHSA);
  – Any information on rate justification that will be publicly available; and
  – The other additional information that must be provided (Section 2715A; for example transparency with respect to claims payment policies and practices; Data on enrollment and disenrollment; etc).

For example, the standalone 4-page disclosure may want to include a reference to the other health plan information that is available to consumers (such as the data called for by Section 2715A), and indicate where it can be found; ideally, all in one place.

• Require the standardized medical and insurance definitions and terms be used in all consumer-facing documents (not just insurance disclosures), and all insurer communications to state agencies and HHS. For example, when state agencies or insurers report complaint data to HHS, they should adopt the same consistent terms and definitions.

Finally, we ask that the consumers testing explore — in a realistic manner — how and why consumers understand and make use of the document, and whether it meets the goals of being appealing, understandable, meaningful and helpful. Such a process should include focus groups, preference testing, pretesting, and diagnostic usability testing, to iteratively develop and refine the prototype. The testing design must avoid these potential pitfalls:

• **Most conventional focus groups actually measure the wrong thing.** They do not measure what people think when making a purchase. They measure what people think when participating in a focus group.

• Since there are often major differences between what people say and what they do, it is better to **watch users as they attempt to perform tasks** with the disclosure forms or the side-by-side comparison tools, such as the web portal. Direct observation of this nature always needs to be done to supplement focus groups.13

• People have little, if any, reliable access to the cognitive reasoning that underlies their decision-making. In most instances, people are unaware of the factors that influence their responses.14 Again, this points to the need for usability testing to compliment focus group activity.
END NOTES

2 Including grandfathered plans (Sec. 10103).
3 HHS may want to leverage the recent interagency work done to redesign model privacy notices, specifically the very detailed requirements about the appearance of the form (font size, leading, printing, color, etc.) (See pages 30-35 of: http://www.ftc.gov/privacy/privacyinitiatives/PrivacyModelForm_FR.pdf). Consumer groups would also be happy to provide additional feedback on desirable features.
4 The average U.S. adult reads comfortably—especially about subjects they do not understand well—at an 7th grade level. To reach an even broader audience, a 6th grade reading level is often recommended. Yet the typical health plan document is written at a first-year college reading level. Furthermore, health literacy is a broader concept that goes beyond reading literacy. For example, it includes the ability to process numbers and a basic understanding of how our nation’s health care system works. Unfortunately, just 12 percent of adults are characterized as fully “proficient” in health literacy. The standards that HHS will develop must take into account these myriad comprehension issues.
8 Putting the disparate health plans available to federal employees on a side-by-side basis is an example of the challenge facing HHS. The Consumers’ Checkbook Guide to Health Plans for Federal Employees reports that “hundreds of thousands of employees and annuitants are still enrolled in plans that are much more expensive than average, and that give them no needed extra benefits.”
9 We would be happy to supply a set of references to current, successful “one-stop-shopping” venues.
10 For example, when preparing consumer education materials for the Round 1 Rebid of the Medicare Competitive Bidding Program, CMS reached out to several consumer advocacy groups to review the materials and discuss dissemination plans. As patient advocates who regularly hear from their constituents, these groups were able to provide useful feedback on the readability and understandability of their prepared materials. Additionally, the patient advocacy groups provided valuable feedback on CMS’s dissemination plans. CMS staff remarked on the value of using a collaborative process.
11 For example, this study found striking differences between the Medicare and a younger sample in ability to use disclosure information accurately. http://content.healthaffairs.org/cgi/content/full/20/3/199
13 http://www.userfocus.co.uk/articles/focuspocus.html
14 http://www.userfocus.co.uk/articles/focuspocus.html
The Patient Protection and Affordable Care Act (PPACA) requires health insurance issuers offering individual or group coverage to submit annual reports to the Secretary of Health and Human Services that show the percentages of premiums that the coverage spends on reimbursement for clinical services and activities that improve health care quality, and to provide rebates to enrollees if this spending does not meet minimum standards for a given plan year. The consumer representatives to the NAIC applaud lawmakers both for their understanding of the importance of setting minimum standards for medical loss ratios and also for the strong emphasis in PPACA on improving quality of care.

PPACA directs the NAIC to establish uniform definitions of activities being reported to the Secretary and standardized methodologies for calculating measures of these activities no later than December 31, 2010. The NAIC consumer representatives believe it is critically important that the regulations prohibit insurers from classifying or reclassifying certain administrative expenses as medical expenses, and from taking other actions unrelated to quality improvement that would automatically increase their medical loss ratios. We believe that allowing insurers to boost their medical loss ratios (MLRs) in such artificial ways would violate Congressional intent.

We also believe that because the development of definitions and measurements of insurers’ MLR requirements is of such critical importance to consumers, the process of developing the definitions and standards must be transparent and include consumer group participation and input.

**Background and Discussion**

Section 2718(C) provides that, beginning not later than January 1, 2011, health insurance issuers offering group or individual health insurance coverage must with respect to each plan year provide an annual rebate to each enrollee under such coverage if the ratio: (1) the amount of premium revenue the issuer spends on reimbursement for clinical services provided to enrollees and activities that improve health care quality to (2) the total amount of premium revenue for the plan year (excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of PPACA) is less than the following percentages, referred to as “the applicable minimum standards”:

- 85 percent for coverage offered in the large group market (or a higher percentage that a given state may have determined by regulation); or
- 80 percent for coverage offered in the small group market or in the individual market (or a higher percentage that a given state may have determined by regulation), except that the Secretary may adjust this percentage for a state if the Secretary determines that the application of the 80 percent minimum standard may destabilize the individual market in that state.

Section 2718(b)(1)(B)(ii) requires that beginning on January 1, 2014, the determination of whether the percentage that the coverage spent on clinical services and quality improvement exceeds the applicable minimum standard (under Section 2718(b)(1)(A)) for the year involved shall be based on the average of the premiums expended on these costs and total premium revenue.
for each of the previous three years for the plan. PPACA also directs the NAIC to develop uniform definitions and methodologies for calculating these percentages (subject to certification by the Secretary).

In anticipation of the law’s requirement that health insurers meet minimum MLR standards, at least one insurer began taking actions that would make it much easier for the company to comply with the law simply by reclassifying certain administrative expenses as medical expenses. As reported widely by the media, WellPoint executives told investors in March they already had begun reclassifying several categories of expenses that would result in a substantial increase in its 2010 MLR. The company said its reclassifications involved expenses related to its “nurse hotline” and health and wellness activities, including disease management and medical management programs, and expenses pertaining to “clinical health policy.” By reclassifying these expenses, WellPoint projected that its 2010 medical loss ratio would increase by 170 basis points, or 1.7%. The Office of Oversight and Investigations for the U.S. Senate Commerce Committee noted in an April 14, 2010, report that because WellPoint expects to collect more than $30 billion in premiums from its commercial health customers in 2010, “this ‘accounting reclassification’ means that the company has converted more than a half a billion dollars of this year’s administrative expenses into medical expenses.”

Other insurers are expected to follow WellPoint’s lead. Insurers have proposed such reclassifications in the past when states have considered adopting minimum MLR requirements. When California was considering minimum MLRs in 2007, one insurer proposed that any services to improve health outcomes or reduce health care costs should be included in the medical portion of the ratio, such as: disease management programs; wellness programs, care management programs, nurse hotlines, quality assurance oversight activities, health information technology expenses; transparency initiatives; and provider credentialing.

It is important to note that until lawmakers began focusing on MLRs, insurers thought that expenses related to those costs were categorized appropriately as administrative costs—not medical costs. Significantly, when the California legislature did not enact a minimum MLR provision, the company took no action to reclassify the expenses.

While NAIC accounting rules pertaining to MLRs define “medical loss” as the value of medical claims an insurer actually paid (“incurred claims”), plus the amount of money the insurer sets aside to pay future claims (“contract reserves”), the Patient Protection and Affordable Care Act will potentially allow insurers to classify a broader set of expenditures as medical. But, as the U.S. Senate Commerce Committee report noted, “Boosting medical loss ratios through creative accounting will not fulfill the new law’s goal of helping consumers realize the full value of their health insurance payments.”

Further, because the new law will in 2014 prohibit insurers from denying coverage or refusing to pay claims for anyone with preexisting conditions, insurers after that date should no longer need to spend as much as they do today on underwriting activities. Similarly, since Congress has passed a healthcare reform package, funds spent on lobbying should be greatly reduced. When underwriting and lobbying-related expenses are reduced, insurers’ MLRs should rise as a direct consequence, which will make it considerably easier for them to comply with the minimum ratios set forth in PPACA. MLRs will rise even further if the amount of money paid in commissions to brokers declines once the exchanges are in operation.

**Recommendations**

As HHS and the NAIC approach the task of deciding how to classify health insurance costs, they must not allow whole categories of administrative work to be re-defined as medical costs, especially if the category or department has only a partial medical care role. While the inclusion of evidence-based quality improvement initiatives in an insurer’s MLR would appear to be what lawmakers intended by including “activities that improve health care quality” in the section of the new law pertaining to MLRs, the new regulations should not allow insurers to classify expenses for which there is little or no evidence that the related activities “improve quality.” For example, most consumers would not consider “utilization review” nurses and other administrators whose job it is to review and often deny physician-recommended treatments to be providing medical care or, in many if not most cases, “improving quality” of their health. Likewise, quality assurance programs and provider credentialing activities are administrative functions that insurers have not considered direct medical expenses in the past and should not be allowed to be reclassified as such now.

Information technology spending is another area too broad to allow wholesale reclassifications. Some investments in IT have contributed to greater adherence to clinical guidelines and, as a result, might have improved quality of care. Further, plans can and should help physician practices make the investments they need to meet the “meaningful use” requirements recently promulgated by the Centers for Medicare and Medicaid Services. Information technology spending can lead to more streamlined operations, fewer mistakes and
duplications and, consequently, better patient outcomes and lower medical costs. But many other areas of IT spending have nothing to do with improving quality. Insurers have invested in information technology to enhance underwriting capabilities, reduce expenses pertaining to paying claims and even to identify unprofitable accounts. It is also important to note that insurers have not in the past included IT expenditures as direct medical costs. Insurers have invested in IT to give them competitive advantages and for research and development purposes. Regulations pertaining to IT spending must include a methodology to ascertain and allocate an appropriate portion of technology infrastructure costs directly tied to quality initiatives—with rigorous oversight.

In addition, “medical management” is such an all-encompassing term that it can include purely administrative functions as well as the salaries of employees whose work does not in any way improve quality. Many “medical management” expenses, including expenses related to “nurse hotlines” and proprietary disease and care management programs, are related more to cost control or expense management than to improving quality. While nurse hotlines can be a useful tool for consumers, there is the potential for them to be used by insurers to reduce utilization without regard to medical necessity.

Health plans frequently cite their disease management programs as evidence of a focus on improving the health of people with chronic conditions. One insurer said recently it has 34 different disease management programs in place. Yet as of 2010, the National Committee for Quality Assurance (NCQA) has accreditation programs for only five disease management programs: asthma, diabetes, chronic obstructive pulmonary disease, heart failure and ischemic vascular disease. (The NCQA has separate preventive health measures for tobacco use, influenza vaccination and pneumococcal vaccination). Many disease management programs operated by health plans lack verifiable evidence demonstrating that they improve patient outcomes.

Health plans should not be discouraged from offering evidence-based disease and care management programs, but no program should be included for which there is insufficient empirical evidence that it improves the health of enrollees. In order to advance and support the overall quality agenda within PPACA, we believe the NAIC could consider as allowable quality improvement expenses the following: expenses related to implementing and maintaining the QI program required by Medicare, Medicaid, the Child Health Insurance Program and other government programs; expenses relating to establishing and updating the data collection and reporting required to comply with the Secretary of HHS’s national strategy to improve the delivery of health care services, patient health outcomes and population health; and expenses related to government QI demonstration projects. Plans should be required to be much more transparent in this area and should be required to provide cost and outcome results of such programs. Before regulators consider allowing these programs to be classified as medical expenses, they should ask the following questions: “Does the program result in reduced claims for the insurer? If yes, does the program also have a documented and demonstrable impact on improved quality? If no, then it should not be construed as a medical expense. If yes, would the insurer offer the program if it did not have an impact on reduced claims? If no, then it should not be construed as a medical expense.”

Consumer-focused services that health plans should be allowed to classify as medical care are professional interpretation and translation services in health care settings for enrollees who are limited English proficient (LEP). For these plan participants, language access resources are an integral part of the clinical encounter. Moreover, health plans should not be discouraged from providing these services to LEP enrollees when communicating with them about covered benefits and other plan information. Unless it is for marketing purposes, plans should also be permitted to consider as “quality improvement” interpretation and translation services used when directly communicating with LEP enrollees.

Other considerations:

• Insurers should be prohibited from grouping their plans together to mask the low MLRs of some of their plans. The new law may incentivize insurers to combine into the largest groups possible to have their most profitable plans offset by their least profitable ones.

• If insurers operate under several legal entities in a state, they should not be allowed to combine results. Insurers separated entities for a reason: to limit liabilities. They should not now be able to combine their entities’ MLRs.

• Medicare Part D and specialized and supplemental products, such as vision only, dental only and Medicare supplemental plans should be exempted from inclusion in the loss ratio requirement, so that the requirement is limited to health insurance.

• Insurers should not have the flexibility to pool their experience across different product lines/markets at their discretion. Additionally, an insurer should not have the flexibility to average its premium equivalents under administrative services only (ASO) contracts. Insurers should also not be allowed to pool their experience across different states.
• The MLR should be based simply on paid claims. Insured claims, as noted earlier, are the sum of claims paid and changes in reserves (not paid claims plus all reserves). Since the review is historical, use of actual claims paid is reasonable and avoids the possibility of insurers gaming the system by manipulating reserves.

• Some insurers would like to have a special consideration or accommodation for their low cost products, e.g., limited-benefit and high-deductible plans and possibly even so-called “mini-med” plans, because, in their view, a high medical loss ratio requirement would discourage insurers from offering such products. Products with lower premiums (made possible by reducing benefits and/or requiring enrollees to pay more out of their own pockets than they would under higher premium products) have a higher percentage of revenue attributable to administrative costs. Because these products shift more of the cost of care from insurers and employers to consumers, they also typically have high profit margins. Insurers should not be given any special consideration in computing the MLRs for such products. Many of these products contribute to the growing number of people who are underinsured.

• The cost of settling claims—considered a loss adjustment expense—must not be included in the MLR numerator used for determining rebates. Expenses related to settling claims are not payments for health services. Including them in the MLR numerator would provide a perverse incentive for insurers to spend more money on denying claims. Although section 2718(a) requires insurers to report their loss adjustment expenses together with incurred claims, it separately requires insurers to report expenditures for reimbursements for clinical services and for activities that improve health care quality. Under 2718(b), only the latter two categories of expenses are considered in determining rebates. “Reimbursement for clinical services” clearly does not include loss adjustment expenses.

• Regulators must insist that health plans be transparent in what they include in the MLR numerator. If the NAIC and HHS allow any expenses related to “quality improvement” activities to be reclassified as medical expenses, consumers must be able to see exactly how much plans are paying on claims. Therefore, plans must be required to report on the amount they spend on the payment of claims, separate from the total amount they report for the numerator in the MLR ratio.

• Finally, it should be noted that insurers gain an important advantage under PPACA, which will boost some MLRs. Small groups currently are defined as groups with 50 or fewer employees. The new law raises that definition to 100 employees. Since small groups have more generous MLR minimums, this definitional change will move groups of 51-100 from large to small groups with a 5% greater MLR allowance, providing additional insurer margins.

An additional—and important—recommendation
If carriers are permitted to shift or reclassify any expenses, they should be required to restate their MLRs over the previous five years using the new standards and definitions so that the public — as well as lawmakers, regulators and shareholders — can see the effects of the new definitions on the reporting of MLRs. There are precedents for requiring such restatements by carriers. It is not at all uncommon for the SEC to require publicly traded companies, including insurers, to restate earnings retrospectively following the discovery or disclosure of information considered material to earnings. Similarly, carriers have restated membership totals after discovering that their previous methods of calculating membership totals were flawed. If the HHS, NAIC and SEC are truly dedicated to transparency, they will insist that carriers restate their MLRs retrospectively for a specified period of time.
Issues Regarding the Application of Annual And Lifetime Limits
Under the Patient Protection and Affordable Care Act (PPACA), all health plans are prohibited from imposing lifetime dollar limits on essential benefits, beginning with plan years starting six months after enactment. Also effective six months after enactment, new individual plans and all group plans are prohibited from imposing “unreasonable” annual limits on the dollar value of benefits, as defined by the Secretary of Health and Human Services. In 2014, annual dollar limits on essential benefits will be prohibited in all plans.

These provisions represent important new protections for consumers. In this brief, we describe how to make these provisions as strong as possible.

Concerns Regarding Annual and Lifetime Limit Provisions
• PPACA is not explicit about the minimum acceptable level of adequate levels of annual limits in place between Sept. 23, 2010 and January 1, 2014. It is critical that such limits are sufficient for patients facing chronic diseases and high medical costs. However, restrictions on annual limits will also have an impact on premiums, which must be considered so that they don’t inadvertently increase the number of low and moderate families who cannot afford coverage.

• Between the period of 2010 and 2014, there may be an incentive for plans that prior to September 23, 2010 did not have annual limits to adopt annual limits as a means of replacing the loss of lifetime limits.

• The restriction on annual and lifetime limits for essential benefits begins in new plan years after September 23, 2010, however HHS is not required to define the essential benefits package by such time.

• Self-insured plans are not subject to the market conduct reviews that individual and commercial plans are; rather, they are subject to US Department of Labor oversight which does not have the enforcement staff to effectively conduct such reviews. Consequently, it will be difficult to confirm that self-insured plans are properly implementing the annual and lifetime limit provisions, with respect to the essential benefits that are covered in these plans.

• The law bans lifetime limits on benefits covered by the essential benefits package. But because self-insured plans never have to conform to the essential benefits package, it is unclear how the ban on lifetime limits will apply to them.

• While the law bans monetary lifetime limits and restrictive annual limits, health plans may still apply non-monetary limits, such as numerical limits on physician visits or hospital days. These non-monetary limits are damaging to the adequacy of coverage for consumers, particularly those with chronic diseases such as cancer, heart disease, and diabetes who have high utilization of health care.
Recommendations

We recommend that HHS rules clarify the following:

- Permitted annual limits on essential benefits must be sufficient to cover medically necessary and evidence-based care of patients with chronic diseases such as cancer, heart disease, and diabetes. The most common plans in the FEHBP could be considered as models.

- Plans that must raise their annual limits to comply with HHS regulations should be allowed to retain their grandfathered status. However, the addition of new annual limits should constitute loss of grandfathered status (e.g., the creation of annual limits in plans which did not previously have such a limit or the lowering of annual limits).

- Because the restrictions on annual and lifetime limits begin prior to the implementation of the essential benefits package, it will be necessary for the HHS Secretary to clearly define what constitutes a covered benefit. This definition should include the full range of services typically needed by patients, particularly those with conditions such as cancer, heart disease or diabetes.

- There must be a strong regulatory process to monitor and enforce the restrictions of annual and lifetime limits on essential benefits in self-insured plans, by HHS and US DoL.

- Recommendations for lifetime and annual limits on essential benefits should be developed in a transparent manner. These recommendations must remain consistent with the evidence-based guidelines developed by experts such as voluntary health organizations and professional medical societies; and consumers and consumer advocates.

- A description of the annual limits should provide details needed by consumers, such as how frequently a service can be obtained and still be a covered under the annual limits (i.e., once a year or once every three years).

- Because health plans may still apply non-monetary benefit limits, HHS and the US DoL should ensure that consumers understand what benefit limits can be applied and how they are in effect in their plans.

- It is possible that health plans may increase the use of non-monetary benefit limits to adjust for the bans in lifetime and annual limits. HHS and DoL should track trends in non-monetary benefit limits across all markets and make this information public.
The Patient Protection and Affordable Care Act (PPACA) contains several provisions related to the coverage of clinical preventive services. The Consumer Representatives to NAIC strongly support the expansion of preventive benefits required under PPACA and have a number of recommendations that should be addressed through regulation to ensure that the law fulfills its promise for patients and consumers, including:

- The need for an open and consultative process to translate broad recommendations into a uniform set of clinical preventive benefits applied consistently across all plans;
- Clarity that recommendations from the United States Preventive Services Task Force (USPSTF), Health Resource and Services Administration (HRSA) and Advisory Committee on Immunization Practices (ACIP) serve as a floor and not a ceiling, for covered preventive services;
- The need for specific guidance as to the appropriate interval for plan updates of preventive benefits;
- The need for transparency and clarity around the use of value-based design in the coverage of preventive benefits to ensure that quality is the primary driver of such policies;
- Assure that insurers and health plans provide information regarding all covered preventive services to enrollees. This should include a definition of the service, and any specific age, frequency, or health pre-conditions. This information should be accessible through a variety of communication channels and sources; and
- A process for ensuring adequate consumer and patient group input into coverage decisions made by USPSTF, ACIP, and HRSA.

**Background and Discussion**

Section 2713 requires a health plan to provide coverage for certain preventive benefits without imposing cost sharing requirements. These benefits include: evidence-based items or services that have a rating of ‘A’ or ‘B’ in the current recommendations of the USPSTF; immunizations that have a recommendation from the ACIP; and, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by HRSA for infants, children, and adolescents, and for women. Nothing in the new law prohibits a plan from providing coverage for services in addition to those recommended by the USPSTF or for denying coverage for services that are not recommended. The law also specifies that the Secretary shall establish a minimum interval of at least a year between the date on which a recommendation is adopted and when a plan is required to incorporate the preventive service into its coverage. And finally, this section allows the Secretary to develop guidelines to permit a health plan to utilize value-based insurance designs.

The coverage of preventive services provision is effective six months after the date of enactment; however, the law exempts from these requirements any individual and group health insurance coverage in effect on or before the law’s date of enactment.

There are four sets of issues that should be addressed with regard to this provision.

First, the recommendations that have been developed by the USPSTF and the ACIP are not always specific, particularly when the benefits include counseling and other interventions. (Smoking cessation benefits – which include both pharmaceutical and counseling components – are a case in point.) The lack of clarity could reflect a lack of evidence or the need for some discretion on the part of the clinician based on the patient’s risk factors, but if the goal is a uniform set of preventive benefits across health plans it is critical that the recommendations are clear regarding covered benefits. Likewise, as HRSA develops recommendations for preventive services going forward, such as guidelines for specific populations such as children and women, there needs to be clarity about the specific benefits to be covered. The Agency for Healthcare Research and Quality is likely the most appropriate entity for developing these specific recommendations; however, the processes for developing these specific benefits should be designed to incorporate input from groups that develop guidelines in the relevant areas.

Second, it is critical that the regulations clearly state that plans are not prohibited in any way from covering preventive benefits for which coverage may not be required by the new law. This is particularly important for those preventive services currently
offered by plans that are not recommended with an A or B rating by the USPSTF or meet other criteria now in the law. The Department of Health and Human Services (HHS) should do everything it can to support and encourage insurers and health plans to broaden their coverage of preventive benefits, consistent with evidence-based guidelines.

Third, the regulation should specifically prohibit the use of preventive benefits as a back-door methodology for underwriting riskier patients. Some insurers and health plans have continued to identify consumers who take advantage of preventive benefits (even at no cost) as likely to cost them more in claims and medical costs. Examples of this include smoking cessation and weight loss programs. When consumers utilize those services, they may be inadvertently identifying themselves as higher risk, higher cost subscribers and enrollees. Insurers and plans must be prohibited from imposing unfair costs or other discriminatory practices against these consumers based on their election of preventive services.

Fourth, it may be useful to recommend that the interval between the adoption of a recommendation and its implementation in plan benefits not exceed one year and one day. The law currently states that it may not be less than one year but does not set a specific deadline.

And finally, it is critical that some caveats be placed around the use of value-based benefit design to ensure that quality is a higher priority than efficiency.

**Section 2715** requires plans to issue a uniform summary of benefits and coverage and standardized definitions. HHS will need to translate this requirement into coverage specifications that ensure patients understand which benefits are covered.

Standard definitions must be implemented in 12 months; and the uniform explanation of coverage documents must be implemented within 24 months. This provision does not exempt grandfathered plans.

Since this requirement goes into effect within 12 months, it is critical that HHS develop the preventive services definitions and standardized coverage language so that all plans will be able to incorporate the language into all of their plan documents, in their marketing materials, on their websites, and in all of their other communication materials by the effective dates. The Department will need to translate these requirements into coverage specifications that ensure enrollees have the access to appropriate, evidence-based preventive items and services, and that both enrollees and employers understand the coverage they have. These documents will be of great value to consumers and employers, but may rely on more specificity and uniformity in the provision of preventive benefits than exists currently.

**Section 4003** outlines the roles and responsibility of the USPSTF with regard to coverage decisions. Although the final health care reform measure does not require increased membership on the Task Force, nor does it create an advisory body to secure additional input from patient and consumer groups, the language appears to be broad enough to accommodate such changes made through regulation.

As a result of the new responsibilities assumed by the USPSTF, ACIP, and HRSA with regard to the coverage of preventive benefits, the regulations must address issues related to the transparency of this new decision-making process. In the case of the USPSTF, it is critical that the membership be expanded beyond the traditional base of primary care clinicians to include recognized and appropriately credentialed experts on the specific disease states that the services are intended to prevent or detect. An alternative to expanded membership is the creation of an advisory body – similar to that created in the House health care reform bill.

In addition, there are some issues that impact implementation of the preventive services provision that are also relevant to many of the other insurance market reforms, such as defining when a plan is grandfathered (and therefore exempt from the preventive services coverage requirement) and when a consumer can appeal. The Consumer Representatives to the NAIC have developed separate white papers on those issues.
Recommendations

• A process must be developed to clearly define and describe the specific preventive services covered under the law with no cost-sharing requirements using a transparent process that is based on the latest evidence and allows for public comment. The process must be sufficiently flexible to allow changes without requiring legislative or regulatory action when evidence of effectiveness of clinical preventive services indicates that the standard of care or the frequency, age parameters or type of service required has changed and that allow deviations from the standard level of care based on The processes for developing these specific benefits should be designed to incorporate input from groups that develop guidelines in the relevant areas increased risk.) (It is critical that this definition be in place to guide States in providing an appropriate level of tobacco cessation benefits to pregnant women.)

• The regulations should state that the interval between the adoption of a recommendation and its implementation in plan benefits not be less than one year (as the law states) or greater than one year and one day.

• The guidelines the Secretary develops with regard to value-based insurance design pursuant to section 2713(c) should incorporate public comment; require the use of evidence-based quality measures; and preserve high value care – making quality a priority over efficiency.

• The regulations should clarify that the USPSTF, HRSA and ACIP guidelines are a floor, not a ceiling for preventive services.

• A mechanism must be developed to ensure that what constitutes a covered preventive service is clearly defined and available to the public for all plans. This mechanism should provide details needed by consumers, such as how frequently a service can be obtained and still be free of charge (i.e., once a year or once every three years). Limitations on free preventive coverage based on patient characteristics (such as minimum age) should also be clear to consumers and contained in the health plan coverage documents. Insurers and health plans should be required to communicate clear and specific information on preventive benefits in plain language through a variety of mechanisms, such as plan materials, policy coverage documents, on websites, and in response to consumer inquiries at customer assistance centers. In addition, this information should be available in multiple languages for low English proficient consumers and other formats for visually and hearing impaired consumers.

• Recommendations from the USPSTF, the ACIP, and HRSA should be developed in a transparent manner that incorporates input from consumer and patient groups through the creation of a clinical prevention stakeholder’s board to make recommendations for clinical preventive services that would be reviewed by the Task Force. The recommendations from the USPSTF must remain consistent with the evidence-based guidelines developed by experts such as voluntary health organizations and professional medical societies; incorporate findings from comparative effectiveness research; and reflect innovations in the efficient delivery of services.

• There must be a strong regulatory process to monitor and enforce the requirements for preventive benefits in self-insured plans, possibly through the new Ombudsman program in HHS.

• The separate recommendations of the Consumer Representatives with respect to the definition of grandfathered plans and applicability of appeals and grievances should also be taken into account when implementing the preventive services provision.
Pre-Existing Condition Exclusions
The Patient Protection and Affordable Care Act (PPACA) contains a provision prohibiting health insurers from excluding children under 19 with pre-existing conditions from being covered under their parents’ insurance plan. The Consumer Representatives to NAIC strongly support prohibiting pre-existing condition exclusions required under PPACA and have a number of recommendations that should be addressed through regulation to ensure that the law fulfills its promise for families with children with pre-existing conditions, including:

- The need for a clear definition of pre-existing condition exclusions that includes all forms of discrimination based on health status;
- The requirement that annual rate submissions include documentation about any rate increases applied to policies that cover children subject to the new protections;
- The need for clear regulation that prohibits insurers from charging children unreasonable premiums based on health status; and
- The requirement that rate filings and market conduct examinations include standardized reporting about changes in underwriting actions and policies.

Background and Discussion
Effective six months after enactment (or September 2010), PPACA prohibits individual and group health plan issuers from imposing pre-existing condition exclusions for children under 19. This policy is critical to helping families purchase adequate coverage for children with pre-existing conditions without any discrimination based on a child’s health status.

However, families with children with pre-existing conditions may still face barriers to coverage based on health status, particularly in regards to affordability of health insurance coverage. While insurers will be required to issue coverage to all children under the age of 19 without the application of pre-existing condition exclusion periods, currently there are not any express restrictions on what families can be charged for such coverage. PPACA is silent on what rates may be charged for children being covered under this provision. Effective in plan years starting January 1, 2014, PPACA requires the use of adjusted community rating, thereby prohibiting insurers from basing premium rates on health status. However, prior to 2014, there are no restrictions on ratings based on health status associated with the prohibition on pre-existing condition exclusions for children.

In a letter to AHIP, Secretary Sebelius stated that the Congressional intent is to prohibit the denial of coverage to children based on preexisting condition exclusion periods. In this statement the Secretary did not clearly express that §2704 is also intended to prohibit rating based on health status. However, the Secretary may still address the affordability issue when issuing regulations.

Additionally, PPACA §1003 adding §2794 to the PHSA, requires the Secretary to establish a procedure through which to review ratings for unreasonable premium increases. However, this provision does not prohibit the application of unreasonable premiums.

While current federal nondiscrimination provisions prohibit group health plans from charging an individual higher premiums based on health status (the group may be charged more as a whole if a member of the group has an existing health condition), this protection does not extend to the individual market. Without any clear restriction on rating for children, individual health insurers are free to make an offer of coverage to children with existing medical conditions at a rate that is simply unaffordable for many parents.
Recommendations

• Pre-existing condition exclusions should be defined to include all the forms of discrimination that a child may face because of their health status, including denial of coverage, the exclusion of their specific condition and treatment for their condition from coverage, and excessive waiting periods. An excessive waiting period should be defined as no longer than 90 days, in line with provision that goes into effect in 2014.

• Regulations on annual rate submissions should require the inclusion of documentation about rate increases (if any) that are applied to policies that cover children subject to the new protections.

• Regulations should clarify that insurers may not charge children unreasonable premiums based on health status. In addition to establishing a procedure through which to review ratings for unreasonable premium increases, the Secretary should also be given the authority to prohibit the application of unreasonable premiums, at least until 2014 when PPACA requires the use of adjusted community rating.

• Regulations should require that rate filings and market conduct examinations include standardized reporting about changes in underwriting actions and policies, and the number of children under 19 that were added to the subscriber’s coverage as a result of the new law.

END NOTES

1 Patient Protection and Affordable Care Act of 2009 (PPACA) §§ 1201, 10103(e), PHSA § 2704.
3 §2705 of the PHSA as amended March 23, 2010.
4 A few states currently have community rating laws in the individual market, which does prohibit the use of health status in rating. However, the vast majority of states permit rating based on health status in the individual market. See http://www.statehealthfacts.org/comparetable.jsp?ind=354&cat=7.
Effective six months after enactment (or September 23, 2010), PPACA requires plans that provide dependent coverage to extend coverage to adult children up to age 26. Insurers are not required to cover the children or spouses of covered adult dependents, although adult dependents can receive coverage under their parent’s plan regardless of marital status. Coverage for adult dependents will terminate on the 26th birthday of the covered dependent. Prior to 2014, for grandfathered group plans (plan years beginning before the date of enactment or March 23, 2010), insurers will be required to cover adult dependents only if the adult child is not otherwise eligible for employer-sponsored coverage. The Consumer Representatives to NAIC strongly support this protection under PPACA and have a number of recommendations that should be addressed through regulation to ensure that the law fulfills its promise to provide adult dependents with access to affordable, adequate coverage during a transitional period in their lives.

**Background and Discussion**

**Definition of dependent.** The PPACA calls for the Department of Health and Human Services to define who will qualify for coverage as an adult dependent. States today use a wide variety of definitions with respect to young adults’ eligibility for dependent coverage; some are narrower and others are quite broad. For example, New York provides coverage for unmarried adult children up to the age of 29, regardless of educational status or financial dependence. It is important that states with broader coverage expansions not be pre-empted by the new federal extension of dependent coverage.

**Impact on recent college graduates.** This provision does not go into effect until plan years beginning after September 23, 2010. For plans that run on a July to June cycle, for example, it will not go into effect until July 1, 2011. In the meantime, thousands of young adults will graduate from college and lose coverage under their parent’s health insurance. The current language does not provide for a special enrollment period for these recent graduates, potentially forcing them to remain uninsured until the next open enrollment period in to the plan. This protection needs to be extended as soon as possible to these young adults and this can be achieved by including in the regulations a special enrollment period of 90 days for this year’s crop of graduates or any other young adult who loses coverage before the provision goes into effect. On April 19, 2010, Health and Human Services Secretary Sebelius issued a statement noting HHS’s efforts to work with insurers to voluntarily expedite extending coverage to adult dependents prior to the September 23, 2010 deadline. Consequently, over fifty-five insurers have agreed to begin extending dependent coverage on June 1, 2010. The Consumer Representative to NAIC applauds HHS and the health insurers for the agreement to ensure there are no gaps in coverage for adult dependents graduating this spring. Health plans should also provide advance notice to all plan enrollees of this special enrollment right to dependents in writing.

**Issues of affordability.** The PPACA does not include any provisions with respect to premium rating for adult dependents prior to the implementation of modified community rating in 2014. Unless regulations provide otherwise, an insurer might be free to charge a 25 year old adult dependent significantly more than a 6 year old or a 17 year old dependent. In addition, the dependent coverage provision in PPACA does not clearly specify that adult dependents are to be treated as any other dependent child with regards to premiums and employer contributions. Consequently employer plans may extend coverage to adult dependents but fail to make the same contributions as they would for minor dependent children. In addition, health insurers may seek to create a new category for coverage, for example instead of individual or family coverage, they may create a new classification for family groups with adult dependents, thus increasing premiums for the entire family. In line with the language of PPACA, regulations should further clarify that adult dependent children are to be treated in the same manner as minor children in terms of family composition to prevent this practice. Any attempt to separately underwrite an adult dependent from a minor child should be deemed non-compliant.
Recommendations

- Adult dependents should be defined to include biological, adopted or step-children who otherwise do not have access to a group health insurance plan. No additional restrictions should be placed on the definition of eligible adult dependents, i.e. he/she must reside in the parent's home or must be enrolled in school.

- Regulations should clarify that adult dependent children are to be treated in the same manner as minor children in terms of family composition. Adult dependents should continue to be enrolled through the subscriber's coverage and where appropriate at the same tier structure. For example, adult and child, adult and children or family coverage. This minimizes the administrative burden in implementing the law and also ensures that the dependent is covered at the most affordable premium.

- Regulations should clearly specify that states with more expansive laws extending coverage to adult dependents are not pre-empted.

- Regulations should designate that eligibility for this new option is to be considered a “qualifying enrollment” event so that adult dependents that have recently graduated or otherwise lost family coverage can quickly obtain coverage through their parents’ plans without waiting until the next open-enrollment period. The initial instance of this special enrollment period should be a minimum of 90 days to allow for public education and to provide families sufficient time to understand their options and make educated decisions.

- Regulations should require individual and group insurers to send written notice to beneficiaries about the new dependent coverage under PPACA prior to the start of the special enrollment period. In the case of group coverage, regulations should allow for maintenance of COBRA rights, so that when an adult dependent ages out of dependent coverage on his/her 26th birthday, COBRA continues to be an option, with timely written notice of COBRA eligibility provided to dependent adults in advance of their 26th birthday.

- Regulations should require insurers to document and report on the adult dependents they cover and whether consumer notices were sent as required.

END NOTES

1 Patient Protection and Affordable Care Act of 2009 (PPACA) §§1001, 10103(e), PHSA § 2714
2 HR 4872 §2301
3 New York State Insurance Law§4305(c)(1)
Rescission and Other Post-Claims Underwriting Practices
The Patient Protection And Affordability Care Act (PPACA) provides health insurance enrollees protection against the abusive post claims underwriting practice of rescission. Effective for plan years starting 6 months after enactment, PPACA permits rescissions only for fraud or intentional misrepresentation of material fact and with prior notice to the enrollee. The Consumer Representatives to NAIC strongly support this protection under PPACA and have a number of recommendations that should be addressed through regulation to ensure that the law fulfills its promise to protect consumers from rescissions and other abusive post claims underwriting practices that have the same effect as rescission.

Background and Discussion
Problems of individuals who had health coverage cancelled in the wake of expensive claims for medical care were widely reported in the 1980s and 1990s. This was a clear threat to the health security that people expected from their insurance coverage. During the health care reform debate of 1993-1994, President Clinton's plan provided for guaranteed renewability of all health insurance, as did counter proposals put forth by many others. Calls for guaranteed renewability continued after that national health care reform debate concluded, and in 1996, the protection was included in the federal minimum requirements established for all health insurance by HIPAA.

However, the guaranteed renewability requirements under HIPAA failed to limit the use of rescission as a way for insurers to avoid paying claims for high cost enrollees. Representatives of the insurance industry have testified that rescission is rare and occurs in less than one percent of policies. Even if this estimate is accurate, it is not comforting. One percent of the population accounts for one-quarter of all medical bills. The sickest individuals may be small in number, but they are the most vulnerable and most in need of coverage.

In addition to rescission, health insurance enrollees may be subjected to other post-claims underwriting actions that have a similar effect as rescission, such as cancellation, retroactive or prospective increases in premiums, and policy reformation, among other actions.

The Patient Protection And Affordability Care Act (PPACA) provides health insurance enrollees protections against abusive rescission. Effective for plan years starting 6 months after enactment, PPACA permits rescission only for fraud or intentional misrepresentation of material fact and with prior notice to the enrollee. This protection applies to both individual and group plans in all markets, including grandfathered plans. (PPACA § 1001; PHSA § 2712)

'SEC. 2712. PROHIBITION ON RESCISSIONS.'A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2702(c) or 2742(b).

The intent of the “Prohibition On Rescission” under PPACA is to protect health insurance enrollees from abusive post claims underwriting practices that ultimately lead to rescission. Practices would include, by any reasonable analysis, any other post claims underwriting action that has the same effect as rescission, such as cancellation, retroactive or prospective increases in premiums, policy reformation, among other actions. In implementing PPACA, it is crucial that the federal government and the states adopt a regulatory framework that addresses all aspects of underwriting/post claims underwriting processes that lead to rescission and any other post claims underwriting action that have a similar effect as rescission.

Although rescission should be less of a problem once health status becomes irrelevant to underwriting, post claims underwriting investigations may continue after 2014 as insurers try to avoid cost claims for reasons such as misrepresentation about age, tobacco use, participation in wellness programs and other factors. Standards adopted to protect individuals from abusive post claims underwriting practices in the near term of PPACA implementation will continue to be applicable after 2014.
**Recommendations**

- Establish standard information and health history questions to be used by health plans for health care policy application forms.
- Review and approve all health care policy application forms prior to use of these forms by a health care plan.
- Require health care plans to meet certain requirements with regard to medical underwriting, including requirements that health care plans
  - Review each application for accuracy and completeness,
  - Review specified claims information,
  - Make prescription drug database inquiries,
  - Identify, consult with the applicant, and resolve any omissions, ambiguities, or inconsistencies.
- Require all health care plans to complete medical underwriting prior to issuing a health care policy.
- Allow a health plan to investigate potential omissions or misrepresentations only if it can prove to the State that it has reasonable grounds to suspect that an enrollee intentionally omitted or misrepresented material information during the application process.
- Require health care plans to provide specified notices to subscribers and enrollees of the initiation of a post-claims underwriting investigation.
  - If the health plan initiates such an investigation, the plan shall provide a prompt written notice to the enrollee or subscriber informing them that they are initiating an investigation that could lead to the rescission or cancellation of the health care service plan contract.
  - Such written notice shall include full disclosure of the allegedly intentional material omission or misrepresentation and offer the applicant an invitation to provide any relevant evidence or information within a reasonable timeframe.
- Require health plans to allow enrollees being investigated the opportunity to offer relevant evidence to the insurer within a reasonable timeframe.
- Prohibit a plan or insurer from rescinding or imposing any other post claims underwriting action that has a similar effect of rescission unless specified conditions (see next bullet) are met with regard to whether an applicant “performed an act or practice that constitutes fraud or made an intentional misrepresentation of material facts in the application for the health insurance application.”
- A rescission or any other post-claims action that has a similar effect as rescission, except as otherwise permitted under federal law, can only be effectuated if all the following conditions (a) through (d) exist:
  a. A showing by clear and convincing evidence of **intentional, material fraud** (actual intent to deceive) and a causal relationship between the condition allegedly misrepresented and the condition resulting in the claim. Innocent, minor, or unrelated misrepresentations (e.g. teenage acne or bunions) cannot form a basis for a rescission, and;
  b. Less than **12 months** have elapsed from the application date. After a policy has been in force for a period of **one year** it shall become incontestable as to statements contained in the application, and;
  c. The insurer seeking to rescind or cancel completed all required underwriting procedures and exercised due diligence in underwriting the policy. Where an insurer could have reviewed records and information, ordered medical records, an attending physician statement or taken other underwriting steps prior to issuing a policy, but failed to do so and issued a health insurance policy, it is estopped from rescinding, and;
  d. The request to rescind, or any other post-claims underwriting action that has the same effect as rescission, has been reviewed by an independent review organization, through a review process administered by a government agency, with a determination that conditions a-c has been met.
• Require the health plan to provide full notice to the enrollee or subscriber regarding their rights to file an appeal or grievance of their decision and that their decision is subject to an independent review by a third party.

• Require that the date of cancellation or rescission, if any, shall be no earlier than the date that the enrollee or subscriber receives notification that the independent review organization has made a determination upholding the health care service plan’s decision to rescind or cancel their coverage.

• Require that during a post-claims underwriting investigation and subsequent independent, third party review process, the health insurance policy will remain in full effect, including payment of all claims, and that the health plan will not perform any action that will deter the continuation of ongoing treatment.

• The health plan is required to cover all claims or covered charges under the enrollee’s or subscriber’s health care service plan contract until the effective date of rescission or any other post claims action that has the same effect as rescission.

• Require quarterly reports to the state regulatory agency of all post claims underwriting actions that resulted in rescission or any other post-claims action that has the same effect as rescission, such as cancellation, retroactive or prospective premium increases, benefit limitations, among other similar actions, during the preceding quarter. The results of these reports should be publicly available on a timely basis on the state agency’s website.

• Impose administrative sanctions or civil/criminal penalties upon health insurance plans engaging in any pattern of conduct that has the effect of prolonging independent review processes, conducting unauthorized underwriting practices, failing to implement independent review process decisions, or otherwise demonstrating a pattern of anti-consumer practices of unlawful rescissions or other post-claims action that has the same effect as rescission.
**Grievances and Appeals**

The Patient Protection and Affordability Care Act (PPACA) provides health insurance enrollees with the consumer protections that enable them to ask for a review of an unfavorable decision rendered by an insurer or a health plan. These protections establish a standardized first level internal appeals procedure administered by the plan and then a second level, external, appeals procedure administered by an independent third party. Each step of the appeals procedure guarantees specific protections to the consumer such as:

- accessibility to the appeal procedure at no cost to the consumer,
- the continuation of services and treatment throughout the duration of the appeals process,
- a broad definition of what decisions can be appealed,
- a broad time frame for request of the appeal,
- guaranteed assistance by a knowledgeable consumer advocate in exercising their appeal rights,
- the selection of the external reviewing entity who has no material conflict of interest (professional, familial, or financial) with the insurer or the claimant and is able to conduct the external review de novo,
- full disclosure of the basis for the decision that must be rendered in a timely fashion, and
- collection and publication of appeals data to assist the purchaser and the consumer in their choice of insurer/health plan.

The Consumer Representatives to NAIC strongly support these protections under PPACA and have a number of recommendations that should be addressed through regulation to ensure that the law fulfills its promise to protect consumers by offering a broad-based, standardized, responsive, and effective appeal level review process.

**Background and Discussion**

The Patient Protection and Affordable Care Act (PPACA) outlines a number of provisions to standardize and enhance the consumer appeals processes in existence at plans and in the states.

The specific provisions of the law are defined as follows:

Sec. 2719: Appeals Process “(a) INTERNAL CLAIMS APPEALS.—

“(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum— "(A) have in effect an internal claims appeal process; "(B) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes; and "(C) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process. “(b) EXTERNAL REVIEW.—A group health plan and a health insurance issuer offering group or individual health insurance coverage— “(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or “(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)— “(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or “(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).
This language should be translated into strong consumer protections to fully realize the promise of health care reform. Although several states currently have regulations in place that mandate model appeals procedures, this is by no means universal. For many insurers and health plans in many states, the consumer appeal rights are limited, use not generally available or clear, or have other problems such as:

- Appeal rights are excessively time- and scope-limited, or non-existent,
- The appeal processes do not function as a real review of the original decision, nor do they include a true external review by an independent reviewer with the relevant expertise.
- Consumers are unaware of their appeal rights, have no assistance in navigating the complex quasi-legal steps in the appeal, or are discouraged from exercising their rights due to the lengthy processing time to render a decision or the difficulty of deciphering the decision when actually rendered.
- Industry further discourages the exercise of appeal rights by consumers by refusing to maintain coverage during the resolution of the appeal and/or by discharging patients in the cases of hospitalization.
- The internal appeals process for some insurers, where it exists, serves merely as a rubber-stamp review of the plan's original decision.
- The state regulator provides some impetus to resolve individual complaints, but makes no effort to track complaints by insurer as a measure of their performance.
- The state regulator does not actively evaluate the performance of the insurer or health plan and make data publicly available to enable a purchaser or consumer to make informed choices.
- The state regulator does not exercise oversight of the industry or apply appropriate administrative fines, restrictions on sales, and civil/criminal penalties for patterns of infractions and systemic violations.

Recommendations
The NAIC Consumer Representatives make several recommendations to further define the consumer protections in the law. They are enumerated in the attached chart, catalogued by several guiding principles and referenced to specific consumer problems. They consist of specific recommendations in the following areas:

- Enhanced consumer education and a requirement for consumer assistance in navigating the appeals process
- Strong notice requirements including language, basis, and timeliness requirements
- Broad time frames for exercising appeals
- Continuation of coverage during the appeals process
- No cost to consumers associated with exercise of appeal rights
- Broad definitions of what decisions may be appealed
- Strengthening and, in some cases, establishment of a genuine external appeals process that has as its cornerstone a truly de novo independent review
## Grievances and Appeals

### ISSUE: STRENGTHENING CONSUMER PROTECTION IN THE INTERNAL APPEALS PROCESS

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<td>Accessibility</td>
<td>Consumers are not aware of their internal appeal rights. As a result, they do not exercise those rights despite having issues with insurers’ decisions regarding billing/payment, coverage, delays/denials of treatment including but not limited to pre-authorization and medical necessity determinations. Insurers often dismiss or ignore consumer complaints.</td>
<td>The internal appeals process must be clearly identified in all written material as a consumer right. It should be explained on the insurer’s website, as part of the enrollment package, in the evidence of coverage, and as part of the requirements for consumer notices. Health plans must provide clear explanations in plain language (consistent with § 1311(e)(3)(B) of PPACA) regarding consumers’ internal appeals rights including (but not limited to) how to use it, what forms to use (and permit equivalent language in lieu of a specified form) where to send appeals, what kind of evidence to submit, and what the time frame is before a decision will be rendered. To ensure meaningful access for LEP individuals, plans should comply with the LEP Guidance issued by the U.S. Department of Health and Human Services’ Office of Civil Rights. All consumer complaints, whether written or verbal, about any aspect of care or coverage shall be treated as grievance subject to the content requirements, deadlines, and restricts placed on the internal grievance and appeals process.</td>
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<td>No arbitration requirement.</td>
<td>Consumers experience delays in resolution of their complaint by going to through an extra step of arbitration.</td>
<td>Any additional step for consumers prior to the exercise of their internal appeal rights should be prohibited.</td>
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<td>Security</td>
<td>Any threat of losing coverage would be a barrier to exercising a right to appeal.</td>
<td>Insurers should be required to maintain coverage until final resolution of all appeals, external review and litigation. If an appeal involves a hospitalized patient, hospital discharge should be not allowed until all appeals are concluded.</td>
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<td>Affordability</td>
<td>Any cost to the consumer could serve as a barrier to exercising a right to appeal.</td>
<td>Insurers are prohibited from charging the consumer any fee or cost associated with a complaint or an appeal. Although ERISA regulations prohibit charging the consumer any fees or other costs, this protection should be extended to all policies sold inside and outside the exchange.</td>
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<td>Broad eligibility</td>
<td>Consumers are restricted in the issues on which they can appeal to the insurer.</td>
<td>Consumers should be able to appeal any decision by the insurer to deny or limit coverage for a claim, including (but not limited to) determinations of eligibility, whether care is a covered benefit, determination of whether care is medically necessary or appropriate, coordination of benefits, out of network care for emergency, amount of cost-sharing, etc.</td>
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<td>Broad time-frame for filing</td>
<td>It may be difficult for consumers who are seriously ill or dealing with multiple providers to file an internal appeal in a short time frame.</td>
<td>Consumers should have a broad timeframe for filing an appeal—6 months at a minimum.</td>
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<td>Assistance with appeal process</td>
<td>Consumers are not aware of the information insurers use to render decisions or what documentation consumers could submit that would support their position on appeal.</td>
<td>Insurers should provide clear instructions regarding documentation that consumers can submit to support their case. Any documentation that may help the consumer’s position should be allowed as evidence.</td>
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<td>Full Disclosure of Basis of Decision</td>
<td>Consumers are not aware of the information insurers use to render decisions or what documentation consumers could submit that would support their position on appeal.</td>
<td>Internal reviewers should disclose the scientific basis for their decisions. If a decision is based on policy language, they must identify language protocols or guidelines on which the decision is based and disclose all underlying treatment.</td>
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<td>Timeliness of decision making</td>
<td>ERISA permits plans to require two levels of internal review [29 CFR Part 2560.503-1(c)(2)]. This made sense for people who did not have access to state external review programs due to ERISA preemption. However, once health reform requires external review for all private coverage, the second level of internal review will just hassle claimants and delay payment of claims. Further, a study has shown that health plans tend to uphold their original decision.</td>
<td>Insurers should have one level of internal appeal.</td>
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<td>•Timeliness requires strict notification to consumer</td>
<td>Delay in notifying the consumer about outcomes of the appeals process can lead to delay in decisions and other medical treatment. Currently, the notification requirements for urgent claims is within 72 hours and for post-service claims is within 60 days after plan’s receipt of request for review [29 CFR Part 2560.503-1(h)(4)(i)]. As a result, it is common for weeks, even months, to go by in post-service claims without a decision being rendered.</td>
<td>The time frames for notification of internal review of claims should be shortened. Urgent claims notice requirements should be shortened to 48 hours. Post-service denials notice requirements should be shortened to 30 days. Insurers should have a mechanism to identify urgent appeals. If an urgent appeal involves termination of a hospital stay, the patient should be allowed to stay in the hospital receiving care until the appeal is completed similar to the Medicare requirement.</td>
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<td>Data Collection for Performance Evaluation</td>
<td>Consumers and purchasers often have no access to performance data by insurer (e.g. percentage of claims approved on appeal, length of time before an appeal decision is rendered,) when they purchase a health policy. This is either because no substantive data is collected or it is considered “proprietary” and not public information.</td>
<td>Insurers should be required to collect and make data publicly available regarding their performance in internal appeals on a quarterly basis. Insurers are already required to report the number of claims denied under §2715A of PPACA. That provision cross-references §1311(e), which allows the Secretary to require reporting of additional information. The data standards should reflect, at a minimum, the number of appeals filed, areas of dispute, the timeliness with which decisions are rendered, the disposition of the case with each level of appeal invoked. This information should be submitted to the regulatory agency and made available on that agency’s website.</td>
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<td>Standardization</td>
<td>Consumers are likely to have more than one type of insurance policy in their lives, and should be able to expect similar experiences in all plans.</td>
<td>The internal appeals process should apply to all insurers and to plans sold inside or outside of the exchange. Federal law should establish a minimum standard for the internal appeals process.</td>
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<td>Enforcement</td>
<td>Research finds that insurers tend to uphold their denials at all levels of internal appeal, making the process discouraging for consumers. We know there is a problem because nearly 50% of those consumers who move their appeal to the next level, an external review, win their appeals.²</td>
<td>Regulations should provide strong oversight tools to the state regulator to ensure consumer protections. State commissioners should be required to review internal appeals data and external review data and issue warnings and/or penalties to insurers who consistently deny claims or have complaints brought against them.</td>
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<td>Confidentiality</td>
<td>The appeals process necessarily involves the review of medical records and other sensitive personally identifiable data. The confidentiality of that information is an important concern of consumers.</td>
<td>Insurers and any of their contracted entities should ensure that there are safeguards in place to protect strict consumer confidentiality.</td>
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### STRENGTHENING CONSUMER PROTECTION IN THE STATE-ADMINISTERED EXTERNAL APPEALS PROCESS

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<td>Accessibility</td>
<td>Consumers are not aware of their external appeal rights. As a result, they do not exercise those rights despite having issues with insurers’ decisions regarding: billing/payment, coverage, delays/denials of treatment (pre-authorization and medical necessity determinations).³</td>
<td>The external appeals process must be clearly identified in all written material as a consumer right. It should be explained on the insurer’s website, as part of the enrollment package, in the evidence of coverage, and as part of the requirements for consumer notices. Insurers must provide clear explanations in plain language (consistent with § 1311(e)(3)(B) of PPACA) regarding an enrollee’s external appeals rights including (but not limited to) how to use it, what forms to use (and permit equivalent language in lieu of a specified form) where to send appeals, what kind of evidence to submit, and what the time frame is before a decision will be rendered. To ensure meaningful access for LEP individuals, plans should comply with the LEP Guidance issued by the U.S. HHS Office of Civil Rights. All consumer complaints, whether written or verbal, about any aspect of care or coverage shall be treated as grievance subject to the content requirements, deadlines, and restrictions placed on the external grievance and appeals process.</td>
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<td>Broad eligibility</td>
<td>Health plans determine eligibility for external review [NAIC Model Act Sec. 8(C)(1)]. This limits the issues on which consumers can appeal. This also could discourage some consumers from pursuing external review.</td>
<td>Consumers should be able to appeal any decision by the insurer to deny or limit coverage for a claim, including (but not limited to) determinations of eligibility, whether care is a covered benefit, determination of whether care is medically necessary or appropriate, coordination of benefits, out of network care for emergency, amount of cost-sharing, etc.</td>
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<td>Most states require consumers to exhaust all levels of internal review before they are deemed eligible for an external review [NAIC Model Act Sec. 7]. Many consumers have difficulty navigating this multilevel review process and fail to complete it.</td>
<td>Allow consumers to request an external review after receipt of an adverse determination (whether in the first or second level of internal review).</td>
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<td>Some states impose claims thresholds in order to be eligible for an external appeal. This limits access to external appeal rights for consumers.</td>
<td>Claims thresholds as an eligibility requirement for an external appeal should be eliminated</td>
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<td>Broad time frame for filing</td>
<td>There is a filing deadline of 4 months, after which persons are ineligible to apply for external review [NAIC Model Act Sec. 8(A)(1)]. Insurers have very limited time frames during which consumers can exercise their external appeal rights which further restricts the utilization of external review.</td>
<td>The filing deadline to request an external review should be increased to at least 12 months.</td>
</tr>
<tr>
<td>Affordability</td>
<td>In some states, consumers are required to pay a filing fee each time they exercise their external appeal rights.</td>
<td>There should be no filing fee required for exercising external appeal rights.</td>
</tr>
<tr>
<td>Security</td>
<td>Consumers may be forced to incur expensive out-of-pocket costs for health care while awaiting a lengthy external appeals decision.</td>
<td>Insurers should continue payment for the treatment that is denied or limited or modified in expedited appeal situations until the expedited decision is rendered.</td>
</tr>
<tr>
<td>Assistance</td>
<td>Fear of losing coverage would be a barrier to exercising right to appeal.</td>
<td>Coverage should be guaranteed during the external review process. If appeal involves a hospitalized patient, hospital discharge should not be allowed until all appeals are concluded.</td>
</tr>
<tr>
<td>Assistance</td>
<td>Consumers do not have any reliable source of customer assistance outside of the insurer to seek guidance on how to exercise their rights to coverage, challenge denials, or pursue appeals.</td>
<td>Insurers should provide customer assistance during business hours to consumers to answer their questions regarding the denial or limitation of care, with access to after-hours consultation in emergencies. A medical director must be available 24/7 to answer urgent appeals.</td>
</tr>
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<td>Assistance</td>
<td>Insurers should continue payment for the treatment that is denied or limited or modified in expedited appeal situations until the expedited decision is rendered.</td>
<td>Insurers should be required to refer consumers to consumer assistance offices or ombudsman programs that are required to assist consumers throughout the external review process.</td>
</tr>
<tr>
<td>Timeliness</td>
<td>Timelines for external review under the NAIC Model Act are too long. As a result, consumers are forced to incur expensive out-of-pocket costs for health care while awaiting a lengthy external appeals decision.</td>
<td>Regulations should specify the criteria which qualifies for expedited appeals such as thresholds based on cost and urgency of care. If the cost of care to a consumer would exceed the out-of-pocket maximum as prescribed under the policy, that should constitute an urgent claim on grounds of cost.</td>
</tr>
<tr>
<td>Transparency</td>
<td>Prudent layperson standard requires a level of knowledge not available to many consumers. A reasonable person standard recognizes that a reasonable person may not have clinical knowledge and that a reasonable person in severe pain or distress may act differently than the prudent layperson standard.</td>
<td>The insurer should recognize the “reasonable person rule” which dictates that they would continue payment for the treatment that is denied or limited or modified in expedited appeal situations until the expedited decision is rendered.</td>
</tr>
<tr>
<td>Transparency</td>
<td>Insurers do not have clear instructions in their policies, their consumer information literature (e.g. Evidence of Coverage), or on their websites regarding how to exercise appeal rights. When those instructions do exist, they are not generally understandable by consumers because they contain highly legalistic and opaque language.</td>
<td>There are provisions about disclosure requirements under the NAIC Model Act, Sec. 17, but additional requirements should be implemented.</td>
</tr>
<tr>
<td>Transparency</td>
<td>Insurers should provide clear instructions in a variety of formats, locations, and languages, to explain their appeal procedures. The readability of the instructions should be in plain language and at a minimum designed for understandability in commonly accepted large sans serif face (the current standard from the research is 12-point font).</td>
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<td>Guiding Principles</td>
<td>Consumer Problems</td>
<td>Recommended Solutions</td>
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<tr>
<td>Strong consumer notice requirements</td>
<td>Consumers who are unaware of appeal rights cannot be expected to exercise them. Consumers are unaware what documentation they could submit that would support their position on appeal.</td>
<td>Insurers must notify consumers in writing of adverse determinations on every level of appeal invoked. Insurers should clearly provide instructions regarding documentation that can be submitted by the consumer to support their case. Any documentation that may help the consumer’s position should be allowed as evidence.</td>
</tr>
<tr>
<td>Full disclosure of basis for decisions</td>
<td>Consumers are not aware of the information insurers use to render decisions. Consumers need to be able to understand what affected the outcome of their appeal in order to understand the fairness of the appeal process.</td>
<td>External reviewers should disclose scientific basis for their decisions. If the decision is based on policy language, they must identify language protocols or guidelines on which decision is based, and disclose all underlying treatment. Insurers must include in that written notice the rationale for the denial, an explanation of the right to external review, the procedures on how to initiate the appeal, forms needed to initiate an external review, the cost associated, and the party responsible for the cost of appeal.</td>
</tr>
<tr>
<td>Standardization across states and across plans</td>
<td>Consumers often face completely different definitions of terms, forms, processes, deadlines, standards of proof, and/or consumer protections in different states or in different plans. It is not uncommon to live in one state, require care or have an emergency in one state, receive primary care and follow-up or specialty care in another state, and/or have the insurer be licensed in the laws of a different state.</td>
<td>Regulations on external review should specify standards and common definitions of terms, commonality of forms, deadlines, and procedures for the exercise of other consumer protections across state lines and for all plans, sold inside or outside of exchanges.</td>
</tr>
<tr>
<td>Data Collection for Performance Evaluation</td>
<td>Consumers and purchasers often have no access to performance data by insurer (e.g. percentage of claims approved on appeal, length of time before an appeal decision is rendered,) when they purchase a health policy. This is either because no substantive data is collected or it is considered “proprietary” and not public information.</td>
<td>Insurers should be required to collect and make data publicly available regarding their performance in external appeals on a quarterly basis. Insurers are already required to report the number of claims denied under 2715A. That provision cross-references 1311(e), which allows the Secretary to require reporting of additional information. The data standards should reflect, at a minimum, the number of appeals filed, areas of dispute, the timeliness with which decisions are rendered, the disposition of the case with each level of appeal invoked. This information should be submitted to the regulatory agency and made available on that agency’s website.</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>The appeals process necessarily involves the review of medical records and other sensitive personally identifiable data. The confidentiality of that information is an important concern of consumers.</td>
<td>Insurers and any of their contracted entities should ensure that there are safeguards in place to protect strict consumer confidentiality.</td>
</tr>
<tr>
<td>Strong Oversight and Enforcement</td>
<td>Consumers are forced to seek health care in a marketplace in which the state regulator has limited authority to enforce basic consumer protections because of the underlying statutory authority or understaffing.</td>
<td>Regulations should provide strong oversight tools to the state regulator to ensure consumer protections. These would not generally be invoked for individual infractions, but patterns of infractions and systemic violations. The remedies should include administrative fines, restrictions on sales, up to and including civil and criminal penalties.</td>
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<td>Additional Consumer Protections</td>
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### Guiding Principles

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<tr>
<th>Guiding Principle</th>
<th>Consumer Problems</th>
<th>Recommended Solutions</th>
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</thead>
<tbody>
<tr>
<td>Financial integrity</td>
<td>Consumers are entitled to benefit from a legally defined percentage of profit versus payment of medical benefits from their premium dollars.</td>
<td>Costs incurred during the external review process should be included in the non-medical costs when determining minimum loss ratios.</td>
</tr>
<tr>
<td>Independence of Reviewer</td>
<td>Consumers should have a fair review without influence from the insurer or previous decisions concerning their claim.</td>
<td>The regulator, not the insurer should pick the independent reviewing organization. The insurer or health plan is responsible for notice requirements, such as informing the consumer about their further appeal rights. However, the regulator bears the responsibility for the transparency of the decisions and the disclosure to the public of the performance data tracking by insurer. This data should include: the name of plan; age, gender, geographic location of patient, service/treatment requested, for what illness/condition, time period from request to decision, names and types of physician reviewers and specific rationale for decision, including evidence or clinical guidelines relied upon. There should be no conflict of interest between the review organization, reviewer, or the consumer. A material conflict of interest is defined as a conflict based on professional, familial, or financial areas with the insurer or the claimant. Any external review is de novo.</td>
</tr>
<tr>
<td>Integrity and Expertise of Reviewer</td>
<td>Consumers should be able to count on the use of appropriate expertise in decision making.</td>
<td>The reviewer should have relevant medical expertise. Reviewers should be given wide discretion in weighing evidence based on their own experience and expert medical judgment when determining what is medically necessary. Further, the reviewer should be given authority to evaluate the plan's medical necessity criteria that can then be overturned if they are determined to be inadequate or inappropriate.</td>
</tr>
<tr>
<td>Binding, Publicly Available Decisions</td>
<td>External review is an important consumer protection, providing a mechanism for disputes between insurers and consumers to be resolved fairly, expeditiously, and inexpensively. These decisions should be publically available to consumers so they have access to precedents and to regulators for them to track performance by plan and key patient characteristics.</td>
<td>External review decisions should be binding on insurers and not contestable in court. The regulator has the responsibility for the transparency of the decisions and the disclosure to the public of the performance data tracking by insurer. This data should include: the name of plan; age, gender, geographic location of patient, service/treatment requested, for what illness/condition, time period from request to decision, names and types of physician reviewers and specific rationale for decision, including evidence or clinical guidelines relied upon.</td>
</tr>
<tr>
<td>Maintain right to judicial remedies</td>
<td>Consumers should not have to give up their rights to other judicial remedies to get a fair external review.</td>
<td>All existing federal and state judicial remedies are preserved. Contracts must comply with existing state and federal law.</td>
</tr>
</tbody>
</table>

### END NOTES

3. Consumers Union and the Kaiser Family Foundation did a report on external appeals in the states which provides more information on the importance of accessibility. It is available at http://www.consumersunion.org/health/hmo-review/17-mistakes.html.
Long Term Care Insurance: The CLASS Act and Coordination With Other Benefits

Title VIII of the Public Health Act, as amended by the Patient Protection and Affordable Care Act of 2009 (PPACA) establishes a national voluntary insurance program for long-term care, the Community Living Assistance Services and Supports, or the CLASS Act, the legislative legacy of Senator Edward Kennedy. Individuals who enroll in CLASS and become eligible for benefits will receive a daily cash benefit to purchase long term care services and supports intended to assist beneficiaries to remain independent at home or in the community. Many of the benefits of existing, and potentially future, long term care insurance policies sold individually, through groups, or through state and federal public employment entities cover many of the same services offered through CLASS. Medical rehabilitative benefits may also include some services covered by CLASS. Duplicate or overlapping benefits for the same or similar services raises questions about how these benefits will be coordinated with CLASS benefits, if at all.

Background and Discussion

Insurance is regulated by the individual states and most states base their regulatory framework for long-term care insurance in whole or in part on the National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Act and Regulation. The federal government bases federal tax deductibility of long-term care insurance premiums and benefits on selected standards and requirements of the Model Act and Regulation. The federal government also allows states to exempt certain assets protected by a “Partnership” long-term care insurance policy that the state Medicaid program would otherwise be required to take into account upon eligibility for state Medicaid benefits, and from estate recovery actions following the death of such an individual. The NAIC Model Act and Regulation therefore establishes a consistent minimum national standard for individual and group long-term care insurance policies, and for Partnership policies sold within the individual states.

The Problem

The availability of CLASS benefits will impact other benefits that pay for similar services and supports that are part of other insurance products, particularly long-term care insurance policies. Insurance products typically coordinate coverage with the same benefits available from other coverage to prevent collection of benefit amounts that exceed the cost of an insured loss. Section 3203 E of PPACA specifies that CLASS allows coordination with any supplemental benefits sold through an Exchange established under Section 1311 of PPACA, but is silent about how benefits sold through an Exchange, or on the open market, can coordinate with or against CLASS benefits.

CLASS does not prohibit the development of products outside an Exchange that is specifically designed to wrap around or supplement CLASS benefits, nor does it prohibit a product that would fill in one or more specific gaps in CLASS benefits.

The NAIC Model Act and Regulation does not address the issue of any products that might be designed to supplement or wrap around CLASS benefits, but the Regulation does allow limitations or exclusions for services or items paid under another long-term care insurance or health insurance policy. The Regulation does not however address how coordination such might occur, nor does it identify how primary coverage is to be determined when additional benefits are also available under any other
insurance product. In addition, the NAIC Model Act only requires a long-term care insurance policy to meet the requirements of the Model Regulation when benefits are provided for 12 months or longer, leaving a loophole for supplemental or gap benefits with durations of less than 12 months.

In states with Partnership programs, long-term care insurance policies that meet certain federal and state requirements provide one dollar of Medicaid asset protection for each dollar of benefits paid out by the policy. The state Medicaid program agrees to exempt those protected dollars if and when an individual applies for state Medicaid benefits, and to exempt them from estate recovery actions. It is unclear what effect CLASS benefits will have, if any, on assets that are protected by Partnership policies in the event an individual is covered by both; or how consumers will be informed of any conflict, or the lack of a conflict, between the two types of coverage.

Recommendations
The NAIC Model Act and Regulation should be amended to establish the rules under which coordination of benefits can occur and the standards that must apply to policies and riders specifically written to supplement items, services, and supports for people receiving long-term care. For instance:

• Identify the types of products that can be sold to supplement any long-term care benefits a person might be eligible to receive.
  – Establish minimum daily benefits, durations, and other rules for benefits that supplement, wrap around, or fill a gap for any other benefits a covered person might have
  – Require that eligibility standards could not be different than the benefits being supplemented
  – Establish disclosures, sales and marketing rules, and policy form standards that would apply to supplemental products
  – Specify how would benefit be coordinated between a supplemental product and any other benefits a person might have, and how those rules would apply if a person defers a benefit, or allows an existing benefit to accumulate for later withdrawal
  – Establish rating and loss ratio standards that would apply to supplemental policies that would presumably be taking far less risk
  – Develop marketing standards to take into account the presence of CLASS benefits and the relationship to long-term care insurance, as well as if or how protected assets are affected in long-term care insurance policies sold in conjunction with Partnership programs.

• Develop standards for coordination of benefits in existing long-term care policies and riders with CLASS Act benefits.
  – Determine what coordination standards should apply to benefits available through the CLASS program with any other benefits a person has for similar services, supplies, or supports
  – Determine whether the benefits of a long-term care insurance policy, or any other benefits, can be offset against benefits available through the CLASS program
  – Determine if existing long-term care insurance policy can be amended to take into account benefits available through the CLASS program, and if so what standards would apply
  – Determine what standards will apply to future coordination clauses in long-term care policies

In the absence of comprehensive nationally standardized rules and requirements insurance products will evolve in the private market and consumers will be disadvantaged or even sold worthless products while regulation and enforcement occurs piecemeal across the country.

While we understand that people cannot enroll for CLASS benefits before January 1, 2013, we encourage the NAIC to begin
the process of modernizing the Model Act and Regulation to address these issues as quickly as possible to make clear what can be sold to supplement or wrap around CLASS benefits, and how coordination of benefits must be written for policies and benefits sold now and in the future. Long-term care insurance is a product sold far in advance of need, and consumers need the certainty of how their benefits will be paid now and in the future.

END NOTES

1 Section 6 B(6); Policy Practices and Provisions, the NAIC Long-Term Care Insurance Model Regulation
2 Section 4 A, Definitions, the NAIC Long-Term Care Model Act
3 The Act is quite clear that CLASS benefits cannot be taken into account for an individual’s eligibility for Medicaid or other public benefits.
HHS Health Reform Organization Chart: New Office of Consumer Information and Insurance Oversight

**HHS Secretary**

**Office of Consumer Information and Insurance Oversight**
- Provides executive direction, leadership and support to the entire Office
- Responsible for planning, evaluation, regulatory affairs, external relations, and administrative management

**Office of Oversight**
- Implements, monitors compliance with, and enforces new insurance market rules, including MLRs
- Performs rate reviews and issues state rate review grants

**Office of Insurance Programs**
- Administers temporary programs:
  - High risk pool
  - Retiree reinsurance

**Office of Consumer Support**
- Collects, compiles and maintains comparative pricing data for HHS website
- Helps consumers obtain maximum benefit from new system
- Establishes and issues consumer assistance grants to states

**Office of Health Insurance Exchanges**
- Develops and implements policies and rules governing state exchanges
- Establishes and issues state planning grants
- Oversees exchange operations

Publication Expected in the Federal Register on April 19, 2010
Tax-Free Employer-Provided Health Coverage Now Available for Children under Age 27

IR-2010-53, April 27, 2010

WASHINGTON — As a result of changes made by the recently enacted Affordable Care Act, health coverage provided for an employee’s children under 27 years of age is now generally tax-free to the employee, effective March 30, 2010.

The Internal Revenue Service announced today that these changes immediately allow employers with cafeteria plans — plans that allow employees to choose from a menu of tax-free benefit options and cash or taxable benefits — to permit employees to begin making pre-tax contributions to pay for this expanded benefit.

IRS Notice 2010-38 explains these changes and provides further guidance to employers, employees, health insurers and other interested taxpayers.

“These changes give employers a unique opportunity to offer a worthwhile benefit to their employees,” IRS Commissioner Doug Shulman said. “We want to make it as easy as possible for employers to quickly implement this change and extend health coverage on a tax-favored basis to older children of their employees.”

This expanded health care tax benefit applies to various workplace and retiree health plans. It also applies to self-employed individuals who qualify for the self-employed health insurance deduction on their federal income tax return.

Employees who have children who will not have reached age 27 by the end of the year are eligible for the new tax benefit from March 30, 2010, forward, if the children are already covered under the employer’s plan or are added to the employer’s plan at any time. For this purpose, a child includes a son, daughter, stepchild, adopted child or eligible foster child. This new age 27 standard replaces the lower age limits that applied under prior tax law, as well as the requirement that a child generally qualify as a dependent for tax purposes.

The notice says that employers with cafeteria plans may permit employees to immediately make pre-tax salary reduction contributions to provide coverage for children under age 27, even if the cafeteria plan has not yet been amended to cover these individuals. Plan sponsors then have until the end of 2010 to amend their cafeteria plan language to incorporate this change.

In addition to changing the tax rules as described above, the Affordable Care Act also requires plans that provide dependent coverage of children to continue to make the coverage available for an adult child until the child turns age 26. The extended coverage must be provided not later than plan years beginning on or after Sept. 23, 2010. The favorable tax treatment described in the notice applies to that extended coverage.

Information on other health care provisions can be found on this website, IRS.gov.

More Support for Young Adults

Posted by Nancy-Ann DeParle on April 27, 2010 at 12:24 PM EDT

When health insurance reform became the law of the land, we knew our work was just beginning. While passing the law was a tremendous accomplishment, the President and his Administration are now focused on the next challenge: making sure the law is implemented smoothly, quickly, and effectively. In fact, the day after the bill passed, the first thing the President asked of his senior staff was “Where are we on implementation?”

One of the most important provisions in health reform for young adults and their families is the new provision that allows young adults to stay on their parents’ health care plan until age 26. This provision takes effect on September 23, 2010, and it could help more than 4.7 million uninsured young Americans.

But we knew that some young adults graduating from college this spring could risk losing their health insurance before the provision takes effect, only to be added back onto their parents’ policy the next time their parents’ plan comes up for renewal on or after September 23rd. That was bad news for families and bad news for insurance companies too. Removing an individual from a health insurance plan and then adding them back on a few months later takes time, and it costs money.
That’s why on April 19, Health and Human Services Secretary Kathleen Sebelius called on leading insurance companies to begin covering young adults voluntarily before the September 23 implementation date required by the new health reform law. Early implementation would avoid gaps in coverage for new college graduates and other young adults and save on insurance company administrative costs of dis-enrolling and re-enrolling them between May 2010 and September 23, 2010. Early enrollment will also enable young, overwhelmingly healthy people who will not engender large insurance costs to stay in the insurance pool.

And we’re pleased to report that the following insurance companies are doing just that:

- Blue Cross and Blue Shield of Alabama
- Blue Cross Blue Shield of Delaware
- Blue Cross and Blue Shield of Arizona, Inc.
- Blue Cross and Blue Shield of Florida
- Arkansas Blue Cross and Blue Shield
- Blue Cross and Blue Shield of Hawaii
- Blue Shield of California
- Blue Cross of Idaho Health Service
- Regence Blue Shield of Idaho
- Wellmark Blue Cross and Blue Shield of Iowa
- Health Care Service Corporation
- Blue Cross and Blue Shield of Kansas
- Blue Cross Blue Shield Association
- Blue Cross and Blue Shield of Louisiana
- WellPoint, Inc.
- CareFirst BlueCross and BlueShield
- Blue Cross and Blue Shield of Massachusetts
- Blue Cross and Blue Shield of Kansas City
- Blue Cross and Blue Shield of Michigan
- Blue Cross and Blue Shield of Montana
- Blue Cross and Blue Shield of Minnesota
- Blue Cross and Blue Shield of Nebraska
- Blue Cross & Blue Shield of Mississippi
- Horizon Blue Cross and Blue Shield of New Jersey, Inc.
- HealthNow New York, Inc.
- The Regence Group
- Excellus Blue Cross and Blue Shield
- Capital BlueCross
- Blue Cross and Blue Shield of North Carolina
- Independence Blue Cross
- BlueCross BlueShield of North Dakota
- Highmark, Inc.
- Blue Cross of Northeastern Pennsylvania
- BlueCross and BlueShield of Tennessee
- Blue Cross and Blue Shield of Vermont
- Blue Cross & Blue Shield of Rhode Island
- Premera Blue Cross
- Blue Cross and Blue Shield of South Carolina
- Blue Cross and Blue Shield of Wyoming
- Kaiser Permanente
- Cigna
- Aetna
- United
- WellPoint
- Humana
- Capital District Physicians’ Health Plan (CDPHP), Albany, New York
- Capital Health Plan, Tallahassee, Florida
- Care Oregon, Portland, Oregon
- Emblem Health, New York, New York
- Fallon Community Health Plan, Worcester, Massachusetts
- Geisinger Health Plan, Danville, Pennsylvania
- Group Health, Seattle, Washington
- Group Health Cooperative Of South Central Wisconsin, Madison, Wisconsin
- Health Partners, Minneapolis, Minnesota
- Independent Health, Buffalo, New York
- Kaiser Foundation Health Plan Oakland, California
- Martin’s Point Health Care, Portland, Maine
- New West Health Services, Helena, Mt
- The Permanente Federation, Oakland, California
- Priority Health, Grand Rapids, Michigan
- Scott & White Health Plan, Temple, Texas
- Security Health Plan, Marshfield, Wisconsin
- Tufts Health Plan, Waltham, Massachusetts
- UCARE, Minneapolis, Minnesota
- UPMC Health Plan, Pittsburgh, Pennsylvania

Today, we marked another step forward in our work to provide coverage to young adults with the release of new guidance from the Internal Revenue Service specifically stating that children can be covered tax-free now on their parents’ health insurance policy. The new guidance also discusses incentives the Affordable Care Act provides for employers to immediately extend health insurance coverage to young adults.

This new guidance will help employers as they work to provide better benefits to their employees and cover more Americans. To learn more, check out the press release and fact sheet (pdf).

*Nancy-Ann DeParle is Director of the White House Office of Health Reform*
VIA EMAIL ONLY

May 9, 2010

Mr. Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup
c/o National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Re: Health Care Quality Expenses

Dear Mr. Felice:

The following comments are sent on behalf of Healthways, Inc. Healthways is the largest and most experienced health, wellness and chronic care management company in the world. Healthways offers comprehensive solutions that improve well-being and decrease healthcare costs.

These comments relate directly to the current definitions of Health Care Quality Expenses (lines 5, 5.1 and 5.2 of the Health Care Exhibit) being developed by your Subgroup.

In particular, we observe that the definitions for Health Care Quality Expenses on lines 5.1 and 5.2 contain undefined terms and are subject to interpretations that may be more limiting than what is contemplated under the PPACA and are intended by the Subgroup.

The line 5.1 definition could be read to require that education target specific conditions, thus, perhaps eliminating health care quality expenses covering education for the healthy and at risk population. Further, the definition requires the direct involvement (an undefined term) of a health professionals (also an undefined term), and those undefined terms could be subject to differing interpretations as to what member education services qualify as Health Care Quality Expenses. If “health professionals” is interpreted to mean those qualified as providers under Medicare or State law, only education provided by higher cost personnel might be allowed as health care quality expenses when evidence suggests that health care education provided by lower cost personnel can be just as effective. The definition also requires "hands on medical education." Those terms are not defined, but if read literally, may scope out health care education provided...
through lower cost methods such as telephone and web-based systems, and may require services to be provided only by those that have attended medical school. If the Health Care Quality Expenses defined in line 5.1 are interpreted more narrowly than you intend, the line 5.1 definition may seriously limit the development and implementation of new intervention models.

We would also note that the line 5.2 definition requirement that wellness programs provide incentives is not in line with the requirements of the PPACA and should be amended to delete the reference to incentives in that definition.

Section 2717 of the PPACA provides some useful guidance that may be helpful in refining the current definitions in lines 5.1 and 5.2. We draw your attention to PPACA Section 2717(a)(1)(D) which reads:

“(a) QUALITY REPORTING.—
“(1) IN GENERAL.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—
“(D) implement wellness and health promotion activities.

and to PPACA Section 2717(b) which reads:

“(b) WELLNESS AND PREVENTION PROGRAMS.—For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program’s participants, and which may include the following wellness and prevention efforts:
“(1) Smoking cessation.
“(2) Weight management.
“(3) Stress management.
“(4) Physical fitness.
“(5) Nutrition.
“(6) Heart disease prevention.
“(7) Healthy lifestyle support.
“(8) Diabetes prevention.
We appreciate all of the hard work you and your Subgroup have done to date in developing the definitions for Health Care Quality Expenses, and recognize the extremely short timeframe that you have been given to finalize those definitions. We do, however, hope that you still have the latitude to consider the comments in this letter in crafting your final recommended definitions for the HHS, and I look forward to further discussions on these matters this week.

Very truly yours,

LOCKE LORD BISSELL & LIDDELL LLP

[Signature]

Norris W. Clark

cc: Todd Sells, NAIC
    Vicki Shepard
    Shane Doucet
    Denise Hanna
Chairman Steve Ostlund  
NAIC Accident and Health Working Group

Dear Chairman Ostlund:

Rural America has long been aware of the effects of competition or the lack there of. An example of this is the concentration in the agriculture sector over the last twenty years. Eighty percent of the meat packing industry is now controlled by three companies; two chemical companies have been buying seed companies so that a very few companies not only control the herbicides and pesticides that farmers need to produce crops, they now also control the seed that farmers plant. There is also increased concentration in the grain business so that a few companies control over half of the purchasing of farmers grain. This concentration means not only lower prices for bulk commodities and higher prices for inputs but it also means less service in many instances such as having to travel many more miles to deliver grain or to pick up inputs.

We at Communicating for America and our farmer and rural small business members from across rural America fear that this concentration could also occur in the health insurance market. Already in some states over seventy-five percent of the individual health insurance market is controlled by one company, and over fifty percent in many other states. Smaller health insurance companies are essential to these markets because they are often quicker to react to the special needs of rural areas and offer innovative insurance products focusing on choice and affordability realizing that one size definitely does not fit all in rural America.

Some smaller insurance companies have already decided that they will not continue to sell in the individual and small group markets that make up most of the health insurance sales in rural areas. The companies could exit the market today leaving many of the self-employed and rural small business employees without coverage. The new risk-pool mechanism helps people that have been uninsured for some time but the newly uninsured would not be eligible without going for six months without coverage. After 2014, there will be help for these people but two and a half years is a long ways away for those without access to affordable health insurance.

CA strongly believes that Association Group Insurance is an important option for those Americans purchasing their own health insurance. Legitimate associations offering group insurance provide members the buying power and administrative savings of employer based group coverage, while also offering the flexibility and portability of individual coverage. As an organization that has more than three decades of experience serving the needs of rural America,
CA has the unique insight and ability to tailor insurance policies to the needs of small businesses, farmers, and self-employed Americans, all of which are the backbone of our rural communities.

Communicating for America has offered endorsed association group health plans to members in many states for more than 35 years with good success. Through the years, all the health insurance endorsements have been with smaller companies who have been willing to work with the association to offer innovative plans with good benefits but also more reasonably priced, such as high deductible plans. Our association has done much more that just offering endorsed health plans. CA has been instrumental in helping to establish state high-risk pools since 1976. Since 1981, the Communicating for Agriculture Scholarship and Education Foundation has been providing scholarships and educational opportunities to young people in rural America to further their education and careers in agriculture and health care. Since 1985, the foundation has had authority from the United States Department of State to sponsor a J-1 training and intern program, and today CA Education Programs operates the largest international agricultural exchange program in the United States. We have testified before Congress countless times on agriculture, tax and healthcare issues. All of these endeavors are accomplished through the power of the association. CA urges the NAIC committee and HHS to include regulations that allow association groups with legitimate associations to continue to exist and operate under the new health reform plan.

Thank You,

Wayne Nelson
CA President
wayne@cainc.org
### NAIC BLANKS (E) WORKING GROUP

#### Blanks Agenda Item Submission Form

| CONTACT PERSON: | __________________________________________________________________________|
| TELEPHONE: | __________________________________________________________________________|
| EMAIL ADDRESS: | __________________________________________________________________________|
| ON BEHALF OF: | Health Reform Solvency Impact (E) Subgroup |
| NAME: | Lou Felice |
| TITLE: | Chair of the Subgroup |
| AFFILIATION: | New York State Department of Insurance |
| ADDRESS: | 25 Beaver Street New York City, NY 10004 |

#### BLANK(S) TO WHICH PROPOSAL APPLIES

- [ ] ANNUAL STATEMENT
- [ ] QUARTERLY STATEMENT
- [ ] INSTRUCTIONS
- [ ] CROSSCHECKS
- [ ] BLANK
  - [ ] Life and Accident & Health
  - [ ] Property/Casualty
  - [ ] Health
  - [ ] Fraternal
  - [ ] Separate Accounts
  - [ ] Other Specify

**Anticipated Effective Date:** Annual 2010, Quarterly 2011

#### IDENTIFICATION OF ITEM(S) TO CHANGE

Add a new supplement and instructions for the recording of comprehensive major medical health insurance business for large group employer, small group employer, and individual.

#### REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

To assist regulators in identifying and analyzing the medical loss ratio for comprehensive major medical health insurance as required in the Patient Protection and Affordable Care Act (PPACA) of 2009 (H.R. 3590).

#### NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms.

Revised 6/13/2009
### SUPPLEMENTAL HEALTH CARE EXHIBIT
(Due July 1 following the end of the Calendar Year)

**REPORT FOR:** 1. CORPORATION _________________________________________________ 2. _____________________________________________ ______________________________________

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<td>11. Federal income taxes not included in line 12</td>
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<td>12. Net gain or loss (Line 9+10+11)</td>
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<td>13. Rebates Paid in Year for Prior Years</td>
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### Rebate Percentage Determination

<table>
<thead>
<tr>
<th>Section</th>
<th>Formula or Description</th>
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<tbody>
<tr>
<td>14.1</td>
<td>Immediately Prior Year</td>
</tr>
<tr>
<td>14.1.1</td>
<td>Reported MLR (line 6.3 from Prior Year Report)</td>
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<tr>
<td>14.1.2</td>
<td>Rebates Paid for Prior Year (from line 13)</td>
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<td>14.1.3</td>
<td>Adjusted Earned Premium (line 1.7 from Prior Year Report)</td>
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<tr>
<td>14.1.4</td>
<td>Rebate Paid Percentage (line 14.1.2/line 14.1.3)</td>
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<tr>
<td>14.1.5</td>
<td>Adjusted Actual MLR for Prior Year (line 14.1.1 + 14.1.4)</td>
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<tr>
<td>14.2</td>
<td>Penultimate Year</td>
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<tr>
<td>14.2.1</td>
<td>Reported MLR (line 6.3 from Penultimate Year Report)</td>
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<tr>
<td>14.2.2</td>
<td>Rebates Paid for Penultimate Year (from line 13 of Prior Year Report)</td>
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<td>14.2.3</td>
<td>Adjusted Earned Premium (line 1.7 from Penultimate Year Report)</td>
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<tr>
<td>14.2.4</td>
<td>Rebate Paid Percentage (line 14.2.2/line 14.2.3)</td>
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<td>14.2.5</td>
<td>Adjusted Actual MLR for Penultimate Year (line 14.2.1 + 14.2.4)</td>
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<tr>
<td>15</td>
<td>Three Year Average Adjusted Actual MLR Calculation</td>
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<tr>
<td>15.1</td>
<td>Current Year Adjusted Actual (line 6.3)</td>
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<tr>
<td>15.2</td>
<td>Prior Year Adjusted Actual (line 14.1.5)</td>
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<tr>
<td>15.3</td>
<td>Penultimate Adjusted Actual (line 14.2.5)</td>
</tr>
<tr>
<td>15.4</td>
<td>Average Ratio for Current Year (lines 15.1 + 15.2 + 15.3 / 3)</td>
</tr>
<tr>
<td>16</td>
<td>Rebate Percentage for Current Year</td>
</tr>
<tr>
<td>16.1</td>
<td>MLR Required Percentage</td>
</tr>
<tr>
<td>16.2</td>
<td>Current Year Actual after three year averaging (line 15.4)</td>
</tr>
<tr>
<td>16.3</td>
<td>Current Year Rebate Required (greater of 0 and line 16.1 – line 16.2)</td>
</tr>
<tr>
<td>17</td>
<td>Rebate Amount (line 1.7 x line 16.3)</td>
</tr>
</tbody>
</table>

### Other Indicators

- Number of Certificates
- Number of Covered Lives
- Number of Plans
- Member Months
**ANNUAL AND QUARTERLY STATEMENT INSTRUCTIONS – LIFE, HEALTH, PROPERTY & FRATERNAL**

**SUPPLEMENTAL HEALTH CARE EXHIBIT**

A schedule must be prepared and submitted for each jurisdiction in which the company has written direct comprehensive major medical health business, or has direct amounts paid, incurred or unpaid for provisions of health care services. This also includes the Federal Employees Health Benefit Plan (FEHBP). In addition, a schedule must be prepared and submitted that contains the grand total (GT) for the company.

Include medical only programs that provide medical only benefits without hospital coverage (defined benefit plans or mini-meds). Does not include self-insured business, Title XVIII Medicare Title, Title XIX Medicaid, vision only and dental only business. Report these lines of business in the other health column.

Business that provides for medical coverage including hospital, surgical, & major medical, excluding State Children’s Health Insurance Program (SCHIP) Medicaid Program (Title XXI) risk contracts should be reported in the other health column.

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Individual (including grandfathered business)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health insurance where the policy is issued to an individual covering the individual and/or their dependents. This includes conversions from group policies unless the premiums and claims for such policies are retained in the group line. Exclude policies reported in column 1A.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 1A</th>
<th>Individual (Grandfathered)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health insurances written prior to enactment of the PPACA of 2009 (HR. 3590). This should include policies issued to an individual covering the individual and/or their dependents, as well as conversions from group policies.</td>
</tr>
</tbody>
</table>

| Column 2 | Small Group Employer |
| Column 3 | Large Group Employer |
| Column 6 | Other Health |

All other health care business not reported in columns 1 through 4 including the State Children’s Health Insurance Program (SCHIP), Medicaid Program (Title XXI) risk contracts, Medicare Title XVIII, Medicaid Title XIX, Medicare Supplement, dental and vision only, prescription drug coverage, etc.

**Line 1.1 – Health Premiums Earned**

Include: Direct written premium plus the change in unearned premium reserves and reserve for rate credits. The impact (plus or minus) of Assumed Reinsurance and Accepted Reinsurance

**Line 1.2 – State and Local Taxes**

Include: Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by states. Canadian and other foreign taxes are to be included appropriately. Real estate and payroll taxes levied by a state or locality. Advertising required by law, regulation or ruling, except advertising associated with investments.
State sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.

Any other tax or surcharge imposed generally by a state or locality.

State taxes based on policy reserves, if in lieu of premium taxes. Canadian and other foreign taxes should be included appropriately.

Exclude: Any portion of commissions or allowances on reinsurance assumed that represents specific reimbursement of premium taxes.

Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

Line 1.3 - Federal income and other taxes
Include: All federal income taxes, federal excise taxes or other fees or taxes payable to the federal government allocable to the insurance operations of the company.

All fees assessed pursuant to PPACA sections 9010 and 10907.

Line 1.4 - Regulatory Authority Licenses and Fees
Include: Assessments to defray operating expenses of any state insurance department.

Fees for examinations by state department, including charges for externally contracted examiners and specialists contracted by the state departments of insurance or departments of health for examinations.

Licensing fees for companies or agents paid by the company, rate and form filing fees, holding company filing fees or any other fee levied by state insurance or health departments on companies in order to file mandatory reporting forms, fees to obtain or renew certificates of authority, file articles of incorporation and bylaws, fees paid to file the company's annual and quarterly financial reports, fees paid to the NAIC's Securities Valuation Office in order to file annual financial reports.

Line 1.2 - State Assessments for Indigent Care or Similar Programs

Line 1.4 - State and Local Insurance Taxes
Include: Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by states. Canadian and other foreign taxes are to be included appropriately.

Advertising required by law, regulation or ruling, except advertising associated with investments.

State sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.

State income taxes.

Line 1.5 - State Premium Taxes
Include: State taxes based on policy reserves, if in lieu of premium taxes. Canadian and other foreign taxes should be included appropriately.

Exclude: Any portion of commissions or allowances on reinsurance assumed that represents specific reimbursement of premium taxes.
Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

### Line 1.6 Regulatory Authority Licenses and Fees

Include: Assessments to defray operating expenses of any state insurance department.

Fees for examinations by state departments.

Exclude: Fines and penalties of regulatory authorities.

### Line 2.1 Incurred Claims Excluding Prescription Drugs:

Include: Paid Claims During the Year

Report payments net of risk share amount collected.

The impact (plus or minus) of Assumed Reinsurance and Accepted Reinsurance

Change in Unpaid Claims

Report the change between prior year and current year unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, recoverable for anticipated coordination of benefits (COB) and subrogation.

Change in Incurred but not Reported

Report the change in claims incurred but not reported from prior year to current year. Except where inapplicable, the reserve included in these lines should be based on past experience, modified to reflect current conditions, such as changes in exposure, claim frequency or severity.

Change in Contract & Other Reserves

The amount may be determined as provided in 42 CFR Chap IV (10-01-09 Edition) Section 403.253(b)

Exclude: Prescription drugs reported in line 2.2.

Pharmaceutical rebates received during the year, reported in line 2.3.

Medical incentive pools and bonuses.

### Line 2.2 Prescription Drugs

Include: Expenses for Prescription Drugs and other pharmacy benefits covered by the reporting entity.

Exclude: Prescription drug charges that are included in a hospital billing which should be classified as Hospital/Medical Benefits on Line 2.1.

### Line 2.3 Pharmaceutical Rebates

Refer to SSAP 84.

### Line 2.4 State Assessments for Stop Loss, Market Stabilization and High Risk Pools

### Line 3 Incurred Medical Incentive Pools and Bonuses

Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees...
to share savings with contracted providers.

**Line 5.1 – Health Care Quality Expenses Incurred Including Cost Containment**

**Include:**  
See AHIP letter for the scope of the activities to be included in lines 5.1-5.4  
Cost containment expenses that directly relate to quality of health care:

- Case management activities and chronic disease management that are directly related to the quality of care.
  
- Network access fees to Preferred Provider Organizations and other network-based health plans (including prescription drug networks), and allocated internal salaries and related costs associated with network development and/or provider contracting;
  
- Consumer education solely relating to health improvement and relying on the direct involvement of health personnel (this would include smoking cessation and disease management programs, implementation of wellness and health promotion activities, and other programs that involve hands on medical education);

**Exclude:**  
Cost containment expenses that do not directly relate to the quality of health care. These are reported in line 7.1.

**Line 5.2 – Other Health Care Quality Expenses**

Health care expenses as allowable under the Patient Protection and Affordable Care Act of 2009 (H.R. 3590).

**Include:**  
Prevention of adverse effects of drugs and biological products;
  
- Health care research related to quality, outcomes, cost and utilization and access to health care services;
  
- Implementation activities to improve patient safety and reduce medical errors through appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

**Line 6.1 – A percentage added to the value in line 6 to reflect the lack of statistical credibility in the underlying numbers. A table would need to be inserted with various “tolerance” percentages.**

**Line 6.2 – A percentage added to the value in line 6 to reflect the lower loss ratios historically reported for newer benefit plans. A table would need to be inserted with various “duration” weighted percentages.**

**Line 7.1 – Cost containment not included in quality of care Line 5**

**Include:**  
Expenses that meet the Statutory definition of cost containment expenses but are not actually serve to reduce the number of health services provided or the cost of such services. Exclude cost containment expenses which improve the quality of health care reported in line 5.1. The following are examples of items that shall be considered “cost containment expenses” only if they result in reduced levels of costs or services:

- Case management activities;
- Utilization review;
- Detection and prevention of payment for fraudulent requests for reimbursement;
- Expenses for internal and external appeals processes.
Line 7.2 – All Other Claims Adjustment Expenses

Include: Costs expected to be incurred in connection with the adjustment and recording of accident and health claims defined in subparagraphs 6 a. and 6 b. of SSAP No. 55. Further, Claim Adjustment Expenses for Managed Care Reporting Entities are those costs expected to be incurred in connection with the adjustment and recording of managed care claims defined in subparagraph 7 a. of SSAP No. 55.

Examples of other claim adjustment expenses are:

- Estimating the amounts of losses and disbursing loss payments;
- Maintaining records, general clerical, and secretarial;
- Office maintenance, occupancy costs, utilities, and computer maintenance;
- Supervisory and executive duties; and
- Supplies and postage.

Exclude: Costs reported in lines 5.1 through 5.4

Line 8 – Sales General & Administrative Expenses

Line 8.1 – Direct Sales Salaries, Force Salaries and Benefits of Salaried Personnel involved in Sales

Line 8.2 – Agents and Brokers Fees and Commissions

Line 8.3 – Other taxes (excluding federal income tax)

Include: Guaranty fund assessments and Taxes of Canada or of any other foreign country not specifically provided for elsewhere.

Sales taxes, other than state sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.

Line 8.4 – Other Sales General & Administrative Expenses

OTHER INDICATORS

Line 1 – Number of Certificates

This is the number of certificates issued to individuals covered under a group policy in force as of end of the reporting period. It is not the number of persons covered under individual policies or group certificates. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

Line 2 – Number of Covered Lives

This is the total number of lives insured, including dependents, under individual policies and group certificates as of end of the reporting period. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

Line 3 – Number of Plans

This is the total number of insurance plans issued as of the end of the reporting period.
<table>
<thead>
<tr>
<th>Line 4</th>
<th>Member Months</th>
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</thead>
<tbody>
<tr>
<td>Line 4.1</td>
<td>Previous year’s Member Months</td>
</tr>
<tr>
<td>Line 4.2</td>
<td>Penultimate Year’s Member Months</td>
</tr>
<tr>
<td>Line 4.3</td>
<td>Covered Lives for Tolerance Table</td>
</tr>
</tbody>
</table>

The sum of total number of lives insured on a pre-specified day of each month of the reported period. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

The sum of lines 4, line 4.1 and line 4.2 divided by 12.

Drafting note for discussion:
The Working Group should discuss the usefulness of a subsequent “roll forward” schedule that reflects claims run-off and reconciles to a future date. (Possibly a subsequent date when rebates would be calculated.)
May 10, 2010

BY ELECTRONIC MAIL

Lou Felice
Chair, Health Care Reform Solvency Impact (E) Subgroup

Re: Request for Information: Medical Loss Ratios; Request for Comments Regarding Section 2718 of the Public Health Service Act [75 Federal Register 119,297 (April 14, 2010)] (“RFI”)

Dear Mr. Felice:

The Federation of American Hospitals (“FAH”) is the national representative of nearly 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, including inpatient rehabilitation, long-term acute care, cancer and psychiatric hospitals. We appreciate the opportunity to provide information in response to the NAIC Health Care Reform Solvency Impact (E) Subgroup with respect to the implementation of Section 2718 of the Public Health Service Act (“the Act”).

We appreciate that the NAIC Subgroup is hearing from a broad spectrum of interested parties. Hospitals and other health care providers are important stakeholders in the implementation of health insurance reform and are the entities that provide the clinical services to, and activities with the patient consumers, as well as have the primary responsibility for the quality of those services and activities. As a representative of key stakeholders, the FAH looks forward to providing meaningful input on this policy and others, as insurance reforms move forward.

General Comments

The FAH supports the goals of Section 2718, and its reporting requirements and medical loss ratio (“MLR”) limitations as well as the corresponding need to both (a) establish uniform definitions of these reporting activities, and (b) standardize methodologies for calculating the measures of such activities.

Specifically identifying those insurer expenses that properly belong in the qualifying medical costs category, including appropriate costs to improve the quality of patient care (versus those costs that properly belong in the non-qualifying administrative expense category), is the critical element in ensuring that the intent of the Act – which is to require that a minimum percentage of premium revenue be spent on true medical costs related to patient care and not simply retained by insurers as
profit or to address excessive administrative costs – is effectively carried out. That analysis will
require consideration of the myriad of insurance payment arrangements with a wide variety of
provider configurations to ensure that the determinations focus on actual clinical care delivery and
quality improvement, and not the administrative costs of the delivery system. Thus, the administration
of benefits, establishing coverage parameters, claims adjudication, and like activities must be carefully
excluded from a measurement of claims and quality improvement expenses.

Section 2718 sets mandatory levels of premium dollars for individual, small group, and large
group health plans that must be spent on (1) “reimbursement for clinical services to enrollees,” and (2)
“for activities that improve healthcare quality.” We comment on both categories below.

**Reimbursement for Clinical Services to Enrollees**

**Capitation Payments**: These are non-encounter/non-claim based payments to healthcare
providers in exchange for providing a defined set of services to a defined set of patients (typically $X
per-member-per-month for Y services) – i.e., a way to reimburse providers on a risk-transference
basis for population management functions (e.g., primary care physicians for managing their assigned
enrollees, reference laboratory for providing all lab services to a defined population of insureds,
disease management vendors for managing patients’ chronic disease states, etc.). To the extent that
such capitation payments compensate licensed healthcare providers for their services relative to the
diagnosis and treatment of patients, these should be counted toward the mandated MLR percentage.

Capitation payments, however, typically provide for compensation of more than clinical
services, and thus cannot fully qualify for inclusion in that category. Insurers are increasingly
“carving out” certain services to be managed by other entities which similarly are neither licensed as
healthcare providers, nor do they directly provide medical care to insureds. Often, such “carve-out”
terms are actually wholly-owned subsidiaries of the insurers (e.g., behavioral health plans or
radiology benefit management companies), which have their own administration costs and profit
retention objectives in addition to those of the upstream insurer. In addition, under capitated systems, a
portion of the amounts paid often support a variety of functions which may be contractually
“delegated” to the provider, and which are similarly to be excluded from the clinical services
determination.

Irrespective of how capitation payments are deployed by insurers, only the portion of such
capitation payments that reimburses licensed healthcare providers for direct patient care should be
counted as allowable in the MLR formula. Any remaining portion must be considered as
administrative expense and appropriately segregated out.

**Rebates to Insurers**: Insurers often receive rebates, and the MLR policy should be explicit in
how those rebates should be accounted for in the MLR calculation. Whether in the form of
retrospective payments to insurers (e.g., by pharmaceutical companies) or the retention/non-
distribution of “withholding” or “risk pool” fund balances, the calculation of reimbursement for
clinical services to enrollees in the MLR calculation needs to be reduced by any such rebates, and
other similar benefits insurers receive (such as subsequent claim, reversals, subrogation,
Medicare/Medicaid recoveries, etc.) The FAH urges federal regulators to forego strict time limits as to
how long a rebate must be accounted for in MLRs. We believe time limits are not appropriate as a
way of excluding rebates from the MLR, but if they are instituted they should be very liberal as to
recognize that rebate programs often involve a substantial lag time before they are given.
**Closed Panel HMOs:** There is a comparatively small subset of insurers who operate in a significantly different way than traditional insurers. These so-called “Closed Panel” (staff and group model HMO) programs have integrated many aspects of the healthcare provider delivery system (via the employment of a large number of their in-network physicians and, in a few cases, ownership of their own hospitals and other healthcare facilities) with a health insurance vehicle. We anticipate that these entities will seek a correspondingly different formulation and application of MLR requirements than their traditional insurer counterparts.

Without diving too deeply into this comparatively complex hybrid configuration, the FAH urges that, from an MLR perspective, the same allocation requirements should also apply to Closed Panel provider/insurer systems – but with some additional considerations to ensure uniformity and consistency in approach, including for example:

- Only “provider expenses” and “physician salaries” involved in direct clinical services should be counted for MLR calculation purposes. Costs of any office space and corresponding personnel (and their time) dedicated to health plan operations (and not to the direct delivery of patient care) need to be tracked, quantified and separated from clinical services, and must be considered as non-qualifying administrative expense.

- In order to be considered as a Closed Panel model, the insurer must have “internalized” (i.e., via ownership or employment) the vast majority of its in-network healthcare providers. An entity merely owning/operating a few physician practices (but in all other respects operating like a traditional health insurer) would not satisfy that threshold, and thus should not be considered any differently from a traditional health insurer for MLR calculation purposes.

**Activities That Improve Health Care Quality**

What qualifies as costs related to clinical services to enrollees is a concept that insurers have dealt with for many years in the MLR context under state regulatory policies. However, the inclusion of a separate category specific to activities that improve health care quality is not as common, and requires a close focus by federal regulators to avoid becoming a “catch-all” into which a wide variety of expenses not directly related to patient care and clinical service quality may arbitrarily be placed.

A key policy goal of Section 2718 is to ensure that enrollees receive direct and real value for their premiums, which is the rationale behind setting minimum mandated levels for patient care related costs. This policy was enacted in response to insurance industry data that generally shows, particularly in the individual and small group markets, a significant percentage of premium dollars goes to plan profit or administrative costs. Because this is a ratio calculation, care must be taken to evaluate the costs attributed to the numerator, i.e. clinical services and quality improvement costs, or the integrity of the ratio will be compromised and its measurement diluted, thus thwarting the goals of the legislation.

Accordingly, the FAH urges that the definitions be the product of a careful focus on the goals and, therefore, any costs associated with reimbursement for clinical services furnished to enrollees and activities that improve health care quality fall squarely within those parameters, and not be the product of a flexible or broad interpretation of activities which are not truly clinical services actually furnished directly to an enrollee or an activity which demonstrably has been shown to improve health care quality for patients. Insurers should be prevented from re-characterizing certain historically administrative costs as costs related to activities to improve health care quality in order to satisfy the mandated levels and to avoid enrollee rebates. In our view, the appropriate policy parameter to draw
is to require a direct focus on those costs related to activities specifically designed to improve health care quality for a particular patient.

There are broad categories of costs that may appear to be related to quality improvement, when in actuality the various types of costs within the broad categories need to be closely scrutinized to reach a proper classification. It is not sufficient or appropriate to allow for one type of classification for all types of costs within the broad categories. For example, most activities related to disease management and health/wellness promotion programs are not directly related to quality improvement for particular patients and should be excluded. Also, generalized programs of health education for the population at large, which are often used as much for promotion of the health plan as to be generally informative on health status, should be excluded. However, costs related to specific services furnished by health care providers to individual patients that involve disease management and certain types of patient-centered health/wellness programs should meet the costs counted for the mandate. In contrast, any costs for patient-specific services related to enrollment in a plan should be excluded.

Examples of insurer activities that clearly fall outside of the clinical care umbrella would include utilization review, quality assurance, credentialing, case management, fraud prevention, medical policy-making, referral authorization programs, health plan accreditation, and provider contracting and network management. These activities are administrative in nature and – while some of them may serve to track or report quality, or reduce the occurrence and cost of claims for healthcare provided to patients – they do not in and of themselves serve to improve healthcare quality. As such, they should not be considered as counting toward the mandated percentage of premiums in the MLR equation.

The hospital industry is currently subject to a multitude of different licensing, governance, regulation, reporting requirements and other forms of oversight. In many cases, the additional scrutiny that insurers seek to apply to providers is effectively redundant with other oversight already being done, is unnecessary, and represents administrative costs. Again, these types of costs relate to quality reporting activities and not activities that directly improve healthcare quality for individual patients.

Many healthcare insurers have adopted Pay-for-Performance (“P4P”) programs, under which healthcare providers may be paid “bonuses” for meeting certain performance criteria. To the extent that the bonus payments are determined directly based upon evidence-based quality metrics, those costs should be counted as activities that improve health care quality. However, simply denoting a program as “quality based” or a “delivery system improvement” should not be the end of analysis. While such programs may generally appear to be designed to improve quality of care, these programs often determine bonus payments based on cost-savings or other related efficiency measures that are not actually based on true patient quality improvement processes or the delivery of clinical services. In our view, only the portion of P4P program distributions, however styled, that are specifically attributed to evidence based quality improvement or clinical services delivery should be counted for MLR purposes. Payments related to cost or efficiency performance should be attributed to administrative expenses.

**Level of Aggregation**

Much discussion has focused on the level of aggregation for purposes of the MLR calculation. Allowing the MLR information to be presented and analyzed on an aggregated basis for all products and reported at the holding company level would directly contradict the statute and be inconsistent with its policies. In our view, the statute clearly requires an analysis and enforcement at least to the individual and small group markets and to the large group market, due to the different applicable
percentage floors. Further, we are mindful that the title of the section that imposes this new policy is “ensuring that consumers receive value for their premium payments,” so the implementation approach should provide consumers with the best information available. Thus, the FAH urges federal regulators to require plans to report their MLRs on an entity by entity basis at the state level, and for those entities to differentiate between plans for the individual and small group market and large group market. This approach best fits with the letter and spirit of this legislative directive.

The FAH appreciates the opportunity to provide comments. If you have any questions about our comments or need further information, please contact me or Jeff Micklos of my staff at (202) 624-1500.

Sincerely,
Charles N. Kahn III
President and Chief Executive Officer

[Signature]
May 6, 2010

Sandy Praeger, Chair
Health Insurance and Managed Care (B) Committee

Steve Ostlund, Chair
Accident and Health Working Group Subcommittee

Lou Felice, Chair
Health Reform Solvency Impact (E) Subgroup
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

c/o Todd Sells @ tsells@naic.org

Request for Comments Regarding Section 2718 of the Public Health Services Act (Medical Loss Ratios)

The Academy of Managed Care Pharmacy (AMCP) is pleased to provide comments to the National Association of Insurance Commissioners (NAIC) on implementation of Section 2718 of the Public Health Services Act relating to medical loss ratios.

AMCP is a national professional association of pharmacists and other health care practitioners who serve society by the application of sound medication management principles and strategies to achieve positive patient outcomes. The Academy’s 6,000 members develop and provide a diversified range of clinical, educational and business management services and strategies on behalf of the more than 200 million Americans covered by a managed care pharmacy benefit. They are responsible for a broad and diversified range of clinical, quality-oriented services, programs and strategies including the development and implementation of drug formulary systems.

The provisions of Section 2718 of the Public Health Service Act (PHS Act), which were added by Sections 1001 and 10101 of the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, require health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and activities that improve health care quality, also known as the medical loss ratio (MLR), and to provide rebates to enrollees if this spending does not meet minimum standards for a given plan year.
The PPACA sets an 85 percent minimum standard in the large group market for the percentage of premiums that coverage spends on reimbursement for clinical services and activities that improve quality. It sets an 80 percent minimum standard for the small group and individual markets.

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. Section 2718(c) directs the NAIC to establish uniform definitions of the activities being reported to the Secretary and standardized methodologies for calculating measures of these activities no later than December 31, 2010. These uniform definitions and standardized methodologies that NAIC develops are to be subject to the certification of the Secretary. It is noteworthy that the Secretary, pursuant to Section 2718(d), may adjust the rates if determined appropriate based on the volatility of the individual market due to the establishment of State Exchanges.

The fundamental question before the NAIC is what qualifies as a medical cost for purposes of calculating MLR. AMCP submits that the definition of MLR should recognize essential legislative priorities designed to enhance patient care including medication therapy management (MTM) programs, health information technology (HIT), formulary development, coordinated care activities, and fraud prevention activities.

In the commercial health insurance industry, “medical loss ratio,” or MLR, is defined as the percentage of each premium dollar that insurers spend on providing health care to their customers. For example, if 80 cents of each premium dollar are used to pay medical claims for a health plan’s members, the company has an MLR of 80 percent. An MLR of 80 percent indicates that the insurer is using the remaining 20 cents of each premium dollar to pay expenses that do not directly benefit policyholders, such as salaries, agent commissions, advertising, overhead and profits.

Section 2718(a) of the PHS Act defines MLR as “the percentage of the 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.”

MLR calculations clearly include dollars paid by an insurer to reimburse health care providers for medical services covered under an insured’s policy. AMCP believes the costs incurred by health plans providing both clinical and non-clinical services that either directly or indirectly improve the health care quality delivered to health plan members are legitimately covered under MLR. These services include:

- MTM programs
- Formulary management, including formulary development, formulary exception processes and prior authorization programs
- Coordinated care activities
- Health care quality improvement activities
- Disease management programs
- Health coaching activities
- Transitional care activities
- Quality measurement activities

Health information technology (HIT) development
Fraud prevention activities

**Medication Therapy Management (MTM) Programs**

MTM programs are offered by health plans and other organizations to optimize therapeutic outcomes by improving the use of medications by patients with chronic conditions and multiple medications and to avoid adverse drug events and unnecessary costs.

MTM programs are designed to improve collaboration among pharmacists, physicians, and other health care professionals; enhance communication between patients and their health care team; and optimize medication use for improved patient outcomes. MTM services empower patients to take an active role in managing their medications. The services are dependent upon pharmacists working collaboratively with physicians and other healthcare professionals to optimize medication use in accordance with evidence-based guidelines. MTM services are distinct from medication dispensing and focus on a patient-centered, rather than an individual product-centered, process of care. These services encompass the assessment and evaluation of the patient’s complete medication therapy regimen, rather than focusing on an individual medication product. MTM services help address the urgent public health need for the prevention of medication-related morbidity and mortality. MTM services contribute to medication error prevention, result in improved reliability of healthcare delivery, and enable patients to take an active role in medication and healthcare self-management.\(^2\) Confidence in the value MTM programs provide to particularly high risk patients is evidenced by their inclusion as a required offering by all Medicare Part D plan sponsors and by provisions in the PPACA.

Health plans may contract with pharmacists or other health care practitioners to provide MTM services; in this case such services would be billed to the health plan and be considered as “reimbursement for clinical services provided,” falling under Section 2718(a)(1). Health plans may also provide MTM services through pharmacists or other health care practitioners employed by the health plan. AMCP believes NAIC should classify all MTM services as activities that improve health care quality, falling under either Section 2718(a)(1) or (2).

**Formulary Management**

AMCP believes formulary management is an area that NAIC should classify as part of the MLR calculation under Section 2718(a)(2). Formulary management is an integrated patient care process which enables physicians, pharmacists and other health care professionals to work together to promote clinically sound, cost-effective medication therapy and positive therapeutic outcomes. Effective use of health care resources can improve patient access to more affordable care, provide an improved quality of life, and minimize overall medical costs.

A drug formulary, or preferred drug list, is a continually updated list of medications and related products supported by current evidence-based medicine, judgment of physicians, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health. The primary purpose of the formulary is to encourage the use of safe, effective and most affordable medications.

A formulary system includes the methodology an organization uses to evaluate clinical and medical literature and the approach for selecting medications for different diseases, conditions and patients. Policies and procedures for the procuring, dispensing, administering and appropriate utilization of medications are also included in the system. Formulary systems often contain additional prescribing guidelines and clinical information which assist health care professionals to promote high quality, affordable care for patients. Finally, for quality assurance purposes, managed health care systems that use formularies have policies in place to give physicians and patients access to non-

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formulary drugs where medically necessary through formulary exception processes. Prior authorization can be used for drugs that have a high potential for misuse or inappropriate use. Health plans may limit coverage of drugs to FDA-approved uses, or for unapproved, or off-label, uses that are supported by adequate medical evidence.

The medications and related products listed on a formulary are determined by a pharmacy and therapeutics (P&T) committee or an equivalent entity. P&T committees are comprised of primary care and specialty physicians, pharmacists and other professionals in the health care field. Often P&T committees also include nurses, legal experts, and administrators. The P&T committee is responsible for developing, managing, updating and administering the formulary. Utilization management strategies such as quantity limits, step therapy and prior authorization criteria may be reviewed and approved by P&T committees. Access policies include medical exception process protocols to allow patients coverage for non-formulary drugs under defined circumstances.3

P&T committees evaluate medications after Food and Drug Administration (FDA) approval. Due to the multiplicity of medications on the market and the continuous introduction of new medications, a formulary must be a dynamic and continually revised listing. In order to keep a formulary current, the P&T committee meets regularly to review newly released drugs and/or classes of drugs. The P&T committee reviews some or all of the following:

- Medical and clinical literature including clinical trials and treatment guidelines, comparative effectiveness reports, pharmacoeconomic studies and outcomes data;
- FDA-approved prescribing information and related FDA information including safety data;
- Relevant information on use of medications by patients and experience with specific medications;
- Current therapeutic use and access guidelines and the need for revised or new guidelines;
- Economic data, such as total health care costs, including drug costs;
- Drug and other health care cost data; and
- Health care provider recommendations.

Formulary systems evolve as new information becomes available or resources are developed. Since formulary decisions rely on published clinical information to make those decisions, it is important to have as much quality information as is available. It is estimated that in the coming years, comparative effectiveness research (CER) and genetic-based medicine, also referred to as personalized medicine, will impact formulary systems. The information gained through CER methodology and outcomes will provide P&T committees additional resources to evaluate the use of medication versus alternative treatment options. Through diagnostic tests and targeted therapies, personalized medicine may add complexity to the P&T committee decision making process. P&T committees will have to develop policies and procedures for making individual decisions in addition to the traditional population-based decisions.4

A quality formulary management system contributing to the use of the safest and most effective medications requires considerable management by the health plan at a significant cost. Formulary management clearly fits the definition of an activity that improves health care quality and should therefore be classified by NAIC as part of the MLR calculations under Section 2718(a)(2).

Additional Clinical Services

Additional services that should be considered activities that improve health care quality and be considered part of the MLR calculations under Section 2718(a)(2) are:

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Coordinated care activities
Prior authorization programs
Health care quality improvement activities
Disease management programs
Health coaching activities
Transitional care activities

It has been well documented that initiatives focused on encouraging patient self-management of chronic diseases translate into improved health care quality. One example of success from such a program is the Asheville Project conducted by pharmacists in Asheville, North Carolina. Two employers, the City of Asheville and Mission-St. Joseph's Health System, participated in two initiatives targeting asthma and diabetes. A total of 194 employees met the criteria for participation in the diabetes program. The study assessed both clinical and economic outcomes for up to five years. For patients enrolled in the program, mean hemoglobin A1c levels, a measure of diabetes control, decreased (improved) at every follow-up. Mean HDL-C levels, a measure of cholesterol control, increased (improved) at every follow-up.5

For health plans to continue to fund such programs at the level necessary to see improvements in health care quality, these clinical services must be classified as part of the MLR calculations under Section 2718(a)(2).

Quality Measurement Activities

Increasingly, health plans are expected to participate in quality improvement programs and to report the results not only to improve their internal operations but also to report to third-party payors, government agencies, organizations that are studying quality, and to the public. Health plans must have adequate and appropriate structures and processes in place to monitor and evaluate the quality and effectiveness of health care delivery. Many quality improvement initiatives require additional resources such as staff time, communication development and dissemination, and measurement.

A health plan can seek to assess quality using objective standards and measures. Meeting selected performance standards and measures requires an organization to provide evidence typically in the form of documentation and/or data reports. The following are examples of existing measures from which health plans select:

- Compliance with standards or measures required for voluntary, third-party accreditation
- Performance measures required by a government agency
- Evidence of compliance with voluntary accreditation or government-mandated standards or measures for existing or prospective client(s)
- Internal quality improvement initiatives or projects.

For commercial health plans, the National Committee for Quality Assurance’s (NCQA’s) Healthcare Effectiveness Data and Information Set (HEDIS®) measures serve as a recognized standard for measuring quality. The HEDIS measure set is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Each year, NCQA releases its latest edition of Quality Compass, the nation’s leading database of comparable information on clinical performance and patient experience. In 2009, this included 415 commercial health plan products serving 94 million enrollees.6 It is programs such as those listed above, including disease management programs and health care quality improvement activities, which translate into the health care

quality improvements measured by the HEDIS measure set and reported annually through NCQA’s Quality Compass database.

AMCP believes the annual content of NCQA’s Quality Compass illustrates the broad use of quality measurement as a standard element in health plan delivery of care to its patient populations. As such, AMCP believes both the costs of measuring quality and reporting those measurements must be classified as part of the MLR calculation.

Health Information Technology

Critical to effective patient care in not only the pharmacy arena but across the whole spectrum of responsible patient care are health information technology (HIT) initiatives. AMCP believes HIT initiatives should be classified as part of the MLR calculations under Section 2718(a)(2). Electronic health records and electronic prescribing provide a means to improve access, safety, quality and cost-effectiveness of medication use which is clearly a cornerstone to successful treatment of both acute and chronic health conditions and the ultimate health of a health plan’s members.

Effective electronic prescribing and electronic medical records are essential components of medication reconciliation. Medication reconciliation is the comprehensive evaluation of a patient’s medication regimen anytime there is a change in therapy in an effort to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions as well as to observe compliance and adherence patterns. This process should include a comparison of the existing and previous medication regimens and should occur at every transition of care in which new medications are ordered, existing orders are rewritten or adjusted, or if the patient has added non-prescription medications to their self-care.

Given the federal commitment to establishing functional national HIT standards designed to improve patient care, it is essential that HIT expenses incurred by health plans be included in the MLR calculations under subsection (2) of Section 2718(a).

Fraud Prevention Requirements

With regard to fraud prevention activities, the PPACA includes significant fraud prevention and program integrity initiatives. Health insurers are required to have in place effective procedures to control fraud, abuse and waste and meet such other requirements as the Secretary may impose. Among the procedures that plans will have to include are the following:

- Implementation of procedures to use beneficiary identifiers to identify individuals entitled to benefits so that such an individual’s social security account number is not used, and
- Procedures for the use of technology (including front-end, prepayment intelligent data-matching technology similar to that used by hedge funds, investment funds, and banks) to provide real-time data analysis of claims for payment under this title to identify and investigate billing or order practices that could indicate fraud or abuse.

In addition, the HHS Inspector General will conduct periodic audits with respect to the contracting administrators to determine whether they are in compliance with the requirements. Finally, there are special rules relating to Medicare Parts C and D that require the Secretary to enter into contracts to do, among other things, the following:

- Ensure that each Medicare Advantage plan under Part C has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan; and
- Ensure that each prescription drug plan under Part D has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan.

AMCP believes that the fraud prevention activities should be included in the MLR. Including fraud prevention activities as an administrative cost would have the probable outcome of running counter to the interest of investment
by health insurers in fraud, waste and abuse expenses beyond just the minimum necessary to be compliant with the new PPACA requirements. Including fraud, waste and abuse expenses in the MLR calculation, rather than treating them as administrative costs, would encourage health plans to field more robust fraud detection programs and avoid efforts to pare back those activities. Also, efforts to reduce fraud will have the benefit of further supporting and enhancing clinical services that are covered by the MLR.

The PPACA gives significant priority to efforts to reduce fraud, waste and abuse in health care. The Academy urges NAIC to take this fact into consideration when defining and calculating claims costs and non-claims costs.

AMCP appreciates the opportunity to comment on these extremely important issues. If you have any questions, please contact me at (703) 683-8416 or at jcahill@amcp.org.

Sincerely,

Judith A. Cahill
Executive Director
May 6, 2010

Lou Felice  
Chair, Health Care Reform Solvency Impact Subgroup

Steven Ostlund  
Chair, Accident & Health Working Group

Re: Including Health and Wellness Coaching Services in the Medical Loss Ratio Numerator

Dear Mr. Felice and Mr. Ostlund:

American Specialty Health, Incorporated and its family of companies (ASH) is a leading provider of specialty network management, and prevention and wellness services. ASH provides specialty network management, prevention & health programs including health coaching and fitness programs to health plans, insurers, and employer groups. In its specialty network management programs, ASH provides complementary health care services including chiropractic, acupuncture, naturopathy, dietetic counseling, and occupational, physical and massage therapy. ASH provides evidence-based services in a cost-effective manner.

ASH believes that the NAIC recommendations on defining the medical loss ratio requirements (Public Health Service Act section 2718 as added by PPACA) should specify that expenditures for member health and wellness coaching services (e.g., smoking cessation, weight loss, stress management) should be included in the MLR numerator when the payments are made to health and wellness companies that are accredited, certified or recognized by NCQA and/or URAC for these services. These types of services unquestionably have a direct impact on the care provided to health plan members and thus should be included as either dollars expended for “clinical services” or “activities that improve health care quality”, as specified in section 2718.

If we can provide any further information, please do not hesitate to contact me.

Sincerely,

George DeVries  
Chairman and CEO
May 07, 2010

Mr. Lou Felice
Chair, Health Reform Solvency Impact Subgroup
c/o National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Re: Medical Loss Ratios – Section 2718 of the Public Health Service Act (PHSA)

Dear Mr. Felice:

On behalf of the more than 11,500 members and 20,000 subscribers of the Case Management Society of America (CMSA), we offer the following comments to National Association of Insurance Commissioners (NAIC) regulators and representatives as you consider classification of health plan expenses related to the calculation of Medical Loss Ratio (MLR).

CMSA and their members partner with over 300 health care entities providing case management services including chronic care, complex and integrated case management along the continuum of care. Case managers are licensed health care professionals consisting of nurses, social workers, physicians and pharmacists who practice in all areas of the healthcare continuum; hospital, outpatient clinic, rehabilitation, primary and specialty care, long term care, hospice, home care and medical home. They deliver those services through government programs, employers, workers compensation, wellness programs, commercial managed care, physician practice and independent practice to the consumer. Our members are committed to improving health care quality and ensuring patient safety by providing targeted interventions and services to at-risk individuals in order to ensure the patient receives the right care at the right time in the right setting.

Section 2718(c) of the Public Health Service Act directs the NAIC to establish uniform definitions for activities that health insurance issuers offering individual and group coverage must report under Section 2718(a), including clinical services, activities that improve health care quality and all other non-claims costs and the nature of such costs.

Existing NAIC guidance on this issue —Statement of Statutory Accounting Principle (SSAP) 85, issued in 2002 — identifies case management and disease management programs as “cost containment expenses.” NAIC defines “cost containment expenses” as “expenses that actually serve to reduce the number of health services provided or the cost of such services.” Additional NAIC guidance directs “cost containment expenses” to be allocated as “administrative expenses” when calculating a health plan’s MLR.
CMSA has previously communicated to NAIC representatives its belief that SSAP 85 does not appropriately account for the significant positive impact on clinical quality and health outcomes that disease and case management programs provide in concert with DMAA: The Care Continuum Alliance and URAC. CMSA supports that these activities should more appropriately be classified as costs related to clinical care. In a recent paper developed on minimum loss ratios, the American Academy of Actuaries describes “case management, disease management, 24-hour nurse hotlines, wellness programs” as “akin to benefits than administrative expenses” and appropriately factored into the value of benefits for the calculation of medical loss ratio (American Academy of Actuaries, February 2010).

Specifically, case management programs support the improvement of patient wellness and management of their health care condition(s) through extensive interventions in collaboration with various members of the patient’s clinical team. The case manager performs the primary functions of assessment, planning, facilitation and advocacy, which are achieved through collaboration with the patient and other health care professionals involved in the patient’s care. Key responsibilities of case management have been identified by nationally recognized professional societies and certifying bodies through case management roles and functions research. Role functions of case managers include:

- Conducting a comprehensive assessment of the patients health and psychosocial needs, including health literacy status and deficits, and develops a case management plan collaboratively with the patient and family caregiver
- Facilitating communication and coordination between members of the health care team, involving the patient in the decision-making process in order to minimize fragmentation in the services
- Educating the patient, the family caregiver, and members of the health care delivery team about treatment options, community resources, insurance benefits, psychosocial concerns, chronic condition management, transitions of care, etc so timely and informed decisions can be made
- Empowering the patient to problem-solve by exploring options of care, when available and alternative plans when necessary to achieve desired outcomes
- Assisting the patient and family caregiver in the safe transitioning of care to the next most appropriate level
- Striving to promote patient self-advocacy and self determination

Many aspects of the new healthcare reform law focus on the continued support of chronic care management and care coordination for patients and their caregivers. Yet without the case managers clinical interventions of patient and family assessments, proactive care planning, bi-directional communication, patient and family health coaching, medication adherence management and patient advocacy it will be more of a challenge in meeting positive outcomes for treatment adherence, improved patient safety or enhanced quality of care

Case management, disease management and care coordination support a physician-guided health care delivery system and engage and support patients to mitigate illness and improve long-term health. Wellness, disease and case management services are built on a foundation of evidence-based clinical care and are measured by the clinical impact on the patient’s health status.
CMSA urges the NAIC to support the classification of these services as either “medical expenses” or “quality improvement expenses” for the purpose of calculating a health plan’s MLR under the requirements of The Patient Protection and Affordable Care Act (PPACA), PL 111-148.

The Case Management Society of America looks forward to serving as a resource for NAIC regulators and representatives as you consider these important issues.

Respectfully,

Cheri Lattimer     Margaret Leonard
Executive Director CMSA    President, CMSA

cc: Richard Diamond, Chair, Actuarial MLR Subgroup
    Todd Sells, NAIC Staff
    John Englehart, NAIC Staff
    Brian Webb, NAIC Staff
    Steve Ostlund, Chair, Accident & Health Working Group
May 5, 2010

Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup, NAIC
New York State Department of Insurance
25 Beaver Street
New York City, NY 10004

Dear Mr. Felice:

I am writing on behalf of URAC to offer comments in response to National Association of Insurance Commissioners (NAIC) draft response to a joint request for information published by the Department of Health and Human Services (HHS), Department of Treasury, and Department of Labor in the Federal Register on April 14th concerning the implementation of Section 2718 of the Public Health Service Act, as amended by Section 1001 and 10101 of the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148). URAC would like to offer comments to the calculation of medical loss ratio for individual and group coverage.

URAC accreditation can serve as a valuable resource in vetting clinical services and activities to improve quality as defined by the NAIC. Through the URAC accreditation process insurers can demonstrate that the service provided meets the NAIC cost category identified. For example, the NAIC discussion draft lists case management services in the health care quality expense category (line 5.1) and the cost containment category not included in quality of care (line 7.1). URAC accreditation could be utilized as independent verification of services which clearly fall into the health care quality expense category. A second example is how URAC accreditation could be used to verify prevention of adverse effects of drugs and biological products (NAIC other health care quality expense line 5.2) through the URAC pharmacy benefit management and drug therapy management accreditations.

URAC recommends that:

1. NAIC forms and definitions include a statement that the existence of a valid accreditation from a nationally recognized not-for-profit accrediting body for specific clinical or quality programs or functions will establish presumptive compliance with the NAIC definitions; and

2. The cost of accreditation be counted as a quality cost for medical loss ratio calculations.

This approach would provide to regulators assurance that, where applicable, clinical and quality functions meet nationally recognized standards and provide those insurers who have demonstrated their commitment to quality improvement with clarity and certainty on the treatment of the costs of accredited programs and functions.
Accreditation is widely recognized and utilized by both federal and state regulators as a quality assurance process and quality improvement tool. URAC is currently recognized by four federal agencies and 42 states, as well as the District of Columbia, as a symbol of excellence in the health care industry. Accredited companies have adopted prevailing industry standards pertaining to health care quality, organizational quality, and consumer protections. Legislators and regulators typically recognize accreditation for the quality management program requirements included in URAC’s core organizational quality standards. Additionally, URAC accreditation aids regulators by independently verifying that health care organizations are implementing the highest quality and safety standards in clinical activities.

Accreditation costs are clearly related to ensuring quality in the delivery of health care and should be counted as a direct quality cost for purposes of medical loss ratio calculations. It is important to note that the cost of accreditation is inclusive the costs of preparing for and undergoing accreditation review, in addition to the application costs of accreditation.

Companies undergo URAC review on a two- or three-year cycle to establish compliance with contemporary standards and encourage adoption of leading health management approaches. URAC’s educational approach to accreditation yields conclusive results; accredited companies regularly emerge ahead of the curve in adopting practices that protect and empower consumers, as well as ensure clinical and organizational quality.

Through the accreditation process, URAC galvanizes health care organizations to keep pace with emerging evidence-based clinical and quality improvement standards more readily than if undertaken by legislation or regulation. During the accreditation review, URAC’s team of clinical reviewers examines key internal processes with implications for both quality of care and patient experience.

In addition, URAC is supportive of the conclusions a recent paper developed on minimum loss ratios by the American Academy of Actuaries where they describe case management, disease management, 24-hour nurse hotlines, and wellness programs as more “akin to benefits than administrative expenses” and appropriately factored into the value of benefits for the calculation of medical loss ratio (American Academy of Actuaries, February 2010). These programs and their pharmacy counterparts, drug therapy management and medication therapy management are critical components of population health management programs which support a physician-guided health care delivery system, which supports, engages, and empowers patients to adhere to treatment protocols, reduce the likelihood of illness and improve health care.

Thank you for your time and consideration of URAC’s comments concerning medical loss ratio calculations.

Sincerely,

[Signature]

Alan P. Spielman
President and CEO
MEMORANDUM

To: Lou Felice, Chair, Health Reform Solvency Impact (E) Subgroup
    Steve Ostlund, Chair, Accident & Health Working Group

From: Mary Jo Hudson, Director, Ohio Department of Insurance

Date: May 6, 2010

Re: MLR Calculation

Thank you for the work of the Health Reform Solvency Impact Sub Group and the Accident and Health Actuarial Working Group in developing a MLR standard that will be recommended to HHS. I want to comment on the term “activities to improve health care quality” and propose a specific definition for that term.

The Purpose of the New MLR Requirement

In thinking about the Working Groups’ approach to developing an MLR definition, the following goals of health care reform should be kept in mind.

First, the decision of Congress to include health care quality improvement activities in the MLR was an incentive for carriers to move the current, fee-for-service driven health care system to one that invests in performance and outcomes, leading to greater value for dollars spent, improved efficiency, and better health. Ultimately, unless health care costs are better contained through strategies to improve health care quality, coverage expansions will be unsustainable over time.

Second, the MLR standards established by Congress are an attempt to limit administrative costs associated with providing health insurance coverage. Therefore, in applying the new MLR standards, we as regulators must ensure that only verifiable (auditable) expenses for legitimate health care quality improvement activities are included in the MLR calculation.

The task of the Working Groups to define “activities to improve health care quality” largely involves the development of an approach to meet these two goals. This will require insurance regulators to coordinate their review of financial information with health care quality standards and measures. This can be accomplished by drafting the MLR definition of “activities to improve health care quality” in coordination with national quality reporting and performance measures that will be applied to those same activities.
Principles To Consider

The Working Group should consider the following concepts in developing a definition for “activities to improve health care quality”:

1. Health care quality improvement expenses should be reported on the MLR exhibit in the annual statement blank in sufficient detail to allow comparisons to quality reporting measures developed by HHS under Section 2717 of the PPAACA. This Section requires HHS to consult with health care quality experts and stakeholders in developing health plan reporting requirements related to quality improvement. Quality improvement activities on the MLR exhibit in the annual statement blank should be reported on separate lines consistent those listed in Section 2717 as follows:

   - effective case management;
   - care coordination;
   - chronic disease management;
   - medication and care compliance initiatives;
   - prevention of hospital readmissions;
   - activities to improve patient safety and reduce medical errors by using best clinical practices,
   - activities to encourage evidence based medicine,
   - health information technology; and
   - wellness and health promotion activities.

   Beyond these categories listed in the statute, separate categories should be provided for all activities for which HHS develops separate quality reporting requirements through regulation.

2. If an activity proves to be ineffective at improving health care quality, the related expenses should not be included in MLR. Plans should be given a limited period of time (3-5 years) before the quality improvement components of MLR are assessed and compared to health care quality performance measures and outcomes.

3. Health information technology (HIT) investments should be allowed as MLR expenses if they meet criteria established by the Office of National Coordinator within HHS. The economic stimulus package (ARRA) passed by Congress included federal funding for the widespread adoption of an HIT infrastructure and implementation of electronic health records to improve our nation’s health care system. To carry out this national goal, the Office of National Coordinator will establish national standards that all HIT systems must meet. The MLR definition must be consistent with this national priority to support the adoption of HIT to improve the quality and efficiency of our health care system.

4. Health care quality improvement activities should be allowed if they are in accordance with nationally recognized standards and certification and accrediting bodies.
5. The definition should include specific examples of quality improvement expenses that may qualify as an MLR expense.

Ohio's Proposed Definition

With these principles in mind, the Ohio Department of Insurance proposes the following definition:

“Activities to improve health care quality” shall include those activities identified in Section 2717 of the PPAACA, other activities for which HHS has established quality reporting requirements in accordance with Section 2717, and activities generally recognized by national standards or accrediting or certification bodies as improving health care quality and outcomes. These activities may include:

1. effective case management;
2. care coordination;
3. chronic disease management;
4. medication and care compliance initiatives;
5. prevention of hospital readmissions;
6. activities to improve patient safety and reduce medical errors by using best clinical practices;
7. activities to encourage evidence based medicine;
8. health information technology; and
9. wellness and health promotion activities.

An activity to improve health care quality must be tracked, measured and assessed to determine if it is effective at improving health care quality. If an activity is determined not to be effective, it should not be included as an MLR expense.

Health information technology investments are allowed as MLR expenses if they meet certification standards and programs to be established by the Office of National Coordinator within HHS, which will include meaningful use and the CORE II standards. Once a health information technology system has been adopted and is operational, the ongoing maintenance of that system should not be included as an MLR expense.

Examples of the type of expenses that could qualify as “activities to improve health care quality” include the following:

1. PMPM care management fees (fees paid to providers for care management and other services related to medical / primary care homes);
2. Maternity management programs;
3. Chronic disease management (vendor contracts and/or internal staff);

4. Programs to reduce avoidable hospital readmissions;

5. Medication management (could include reimbursement to pharmacists for medication management; can be linked to medical homes);

6. Patient safety (incentives and programs to increase patient safety in health care facilities and offices);

7. Medical errors (incentives and programs to reduce medical errors);

8. Increased reimbursement for primary care providers including nurse practitioners;

9. HIT investment (to implement medical homes, improve information sharing and coordination of care, reduce duplication of tests and services, reduce gaps in care);

10. Patient compliance (reimbursement to health care workers or for systems that assist patients and assure compliance with treatment plans and medications); and

11. Wellness and health promotion (wellness assessments; nurse hotlines; could include fitness center memberships for members; healthy lifestyle improvement programs including health coaching; preventive care reminders and follow up; incentives for members related to physical activity; obesity reduction; tobacco prevention and cessation)