

April 30, 2010

Mr. Steve Ostlund  
Chair, Accident and Health Working Group

Mr. Lou Felice  
Chair, Health Reform Solvency Subgroup

Re: Medical Loss Ratio under 2718 of the Public Health Services Act

Dear Mr. Ostlund and Mr. Felilce:

We are writing to you as the group of NAIC consumer representatives who have been working on the issues that have arisen concerning the medical loss ratio provisions of the Patient Protection and Affordable Care Act. We write to address an issue raised by Shari Westerfield of the Blue Cross and Blue Shield Association in her letter to you of April 27, 2010—the role of loss adjustment expenses in calculating medical loss ratios for purposes of determining rebates due to consumers under section 2718 of the Public Health Services Act. We realize that this provision is not a model of clear legislative drafting, but believe that the construction that Ms. Westerfield puts on this provision is in error.

The purpose of section 2718 of the Public Health Service Act, added by section 1001 of the PPACA, is, as announced in its title “bringing down the cost of health care coverage.” The strategy that the law adopts for accomplishing this is to require health insurers to spend at least a minimum percentage of premiums on health care services or on activities that improve health care quality for enrollees.

Section 2718 consists of five subsections and requires insurers to provide information accounting for their costs in a number of expenditure categories using a number of different ratios. First, section 2718(a) requires insurers to submit to HHS “a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. This ratio is:

$$\frac{\text{Incurred loss} + \text{loss adjustment expenses (or change in contract reserves)}}{\text{earned premiums}}$$

This ratio is not mentioned again in the statute.

Second, insurers are also required to report three other ratios, namely:

The percentage of total premium revenue, after accounting for collections of risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

- (1) on reimbursement for clinical services provided to enrollees under such coverage;
- (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.

These ratios are:

Clinical services reimbursement/premium revenue + or – risk pooling  
Health care quality activity payments/premium revenue + or – risk pooling  
Other non-claims costs – taxes and regulatory fees / premium revenue + or – risk pooling.

These three ratios also do not play a further role in the statute, although components of them do.

Section 2718(b), the operative section requiring rebates, turns on yet a fifth ratio, different from any of those reported under subsection (a). This ratio is “the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance” for a plan year. . .”, represented as:

Clinical services reimbursement + quality activity costs / premium revenues – taxes and regulatory fees + or – risk pooling

Under 2718(b)(1)(B), this becomes the key formula in the provision. If this ratio falls below 80 percent in the individual or small group market or 85 percent in the large group market (or such higher rate as a state imposes or unless HHS determines that the 80 percent ratio will destabilize the market), the insurer must pay a rebate to its enrollees.

The operative ratio of 2718(b) does not include loss adjustment expenses in its numerator. Although loss adjustment expenses are included in the numerator of the first ratio described in 2718(a), this first ratio (which also does not account for taxes, regulatory fees, or risk pooling) is not the ratio that determines the rebate. Loss adjustment expenses are defined by the Brokers and Reinsurance Markets Association to include:

Loss Adjustment Expense" means all costs and expenses allocable to a specific claim that are incurred by the Company in the investigation, appraisal, adjustment, settlement, litigation, defense or appeal of a specific claim, including court costs and costs of supersedeas and appeal bonds, and including post-judgment interest.

They also may include under some BMRA definitions:

b) post-judgment interest; c) legal expenses and costs incurred in connection with coverage questions and legal actions connected thereto; and d) a pro rata share of salaries and expenses of Company field employees, and expenses of other Company employees who have been temporarily diverted from their normal and customary duties and assigned to the field adjustment of losses covered by this Contract.

These are core administrative functions of insurance companies. Loss adjustment activities do not provide health care services or improve the quality of care received by enrollees. Indeed, a major function of loss adjustment activities is to deny services to

enrollees and to contest their claims to services. It is inconceivable that Congress intended these costs to figure into the numerator of the formula ultimately used to calculate rebates, even though they do appear in one of the other formulas reported by insurers.

We trust that the NAIC and HHS will focus on the intent of Congress and the clear wording of 2718(b), and reject Ms. Westerfield's interpretation of the statute. Please contact Timothy Jost at 540 421 1529 or [jostt@wlu.edu](mailto:jostt@wlu.edu) if we can be of any further assistance in this matter.

Sincerely,

Timothy Stoltzfus Jost  
Wendell Potter  
Kim Calder  
Bonnie Burns  
Elizabeth Abbott  
Kevin Lucia