



May 11, 2010

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

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

Re: Application of Medical Loss Ratio Requirements enacted in the  
Patient Protection and Affordable Care Act (PPACA)

Dear Mr. Felice:

We are writing to provide comments on the implementation of the Medical Loss Ratio (MLR) requirements in the new Section 2718 of the Public Health Service Act, as added by PPACA.

#### Background

HTH Worldwide is a leading provider of international health insurance programs and an innovator in online healthcare information, medical assistance and insurance services around the globe. At present, HTH annually provides health insurance products or services to over 650,000 individuals who travel, study or live outside of their home country, including student, leisure and business travelers. HTH invests in the development of unique products and assets to assist the global traveler, including a directly contracted international network of medical practitioners and facilities in over 180 countries outside the United States. International health plans and services are our only lines of business.

Our company provides health coverage to individuals who live, study, travel or work abroad. We are very concerned about the potential impact of the new MLR requirements (and other provisions in PPACA) on these unique specialty products. Preserving the availability of quality medical insurance for individuals who travel abroad for work or personal reasons is an important component of a robust insurance market. To preserve the availability of these products in the US, we believe that plans providing coverage to individuals living, traveling or working abroad deserve special consideration.

#### “Methodologies for Special Circumstances”

Section 2718(c) states that the National Association of Insurance Commissioners (“NAIC”) shall establish “methodologies (of calculating MLR) designed to take into account the special circumstances of smaller plans, different types of plans and newer plans.” The unique demands

on international health insurance plans appear to fit squarely into the category of plans requiring special consideration.

We respect the positive intent of the new statutory MLR requirements provided in section 2718; unfortunately, to meet the health needs of individuals traveling abroad, it is simply not possible for international plans to conform to an 80 percent or 85 percent MLR. Our global health insurance plans offer lower per member per month (pmpm) premiums (typically ranging from \$130 to \$300 pmpm versus up to \$500 pmpm for primary domestic coverage), but these expatriate plans also require unavoidably higher sales, distribution and administrative/loss adjustment costs associated with doing business abroad. Forcing these unique plans to conform to the proposed MLR will 1) hinder our ability to offer low-premium and high-quality plans to our customers and 2) put us at a competitive disadvantage against non-admitted international health plans, which will not be subject to state or federal standards.

The expense of providing access to and coordinating health care around the world is substantially higher than in the United States. For example, to immediately meet the needs of an expatriate working in China or Japan, our member support lines must be open 24 hours/day, 365 days/year versus just 40 hours a week for a domestic health plan, a fourfold increase in baseline expense. We also have to maintain case management and claims processing employees who speak multiple languages and help navigate cultural and health related issues in 200 countries. This level of expertise is necessary not only to help members and providers to communicate effectively, but also because we often act as the intermediary between local hospitals, physicians, clinics, ambulance services, etc., that are not prepared to deal with U.S. methods of treatments, protocols and payments.

Managing health care outside the U.S. is sometimes a daunting and challenging task. Expatriates can often become ill very rapidly in areas with little to no quality medical care available, and we must take the responsibility of assessing the care available in each location and transporting the members to a location where they can receive adequate medical care immediately. Maintaining the infrastructure and highly trained personnel to manage these difficult cases can be extremely costly, especially if a medical evacuation is involved. If the cases are not managed appropriately, it can result in increased medical risk to a member or even death.

In addition, developing and maintaining a global network of contracted, qualified foreign care givers (in 200 countries) is much more costly and burdensome than developing a domestic network. The expense of administering a worldwide provider network, managing currency risks and paying for care outside the U.S., where there are no widely recognized or standardized systems or even nomenclatures for diagnosis, treatment or billing, is substantially higher. This lack of global standardization prevents international health plans from implementing electronic submission and auto-adjudication of claims, thus limiting our ability to achieve the efficiencies that domestic plans currently enjoy on the overwhelming majority of their claims. Also, we must execute banking arrangements to pay caregivers in over 100 currencies across all time zones. For all of these reasons, the costs of administering overseas care can be approximately three to four times higher than domestic health insurance administrative costs.

Expatriate plan benefits are created with additional services designed to meet the unique needs of individuals living and working abroad. These plans are tailored to each destination country and include support services not included in U.S.-based health plans, such as coverage of political and medical evacuation services. Building and maintaining a truly global platform for member services requires comprehensive online and mobile databases and tools for finding

appropriate doctors, hospitals, pharmacies and medications, as well as translating medical terms and phrases. These are unavoidable medical management costs for international health plans.

Other business requirements intrinsic to specialty international plans often include the need to pay for fronting fees and reinsurance. Worldwide insurance operations can require flexible business partnerships that do not neatly conform to U.S. health benefits standards. These additional costs will penalize specialty programs if PPACA's rules are deemed to apply.

As stated above, PPACA charges the NAIC with the task of establishing uniform definitions of clinical services and activities that improve health care quality and developing standardized methodologies for calculating measures of such activities, including definitions of which activities qualify. While it is not entirely clear that Congress intended to apply PPACA's coverage provisions to individuals living, traveling or working abroad, to the extent that they do, we note that PPACA requires that the MLR methodologies "shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans." Health plans offering coverage to individuals living, traveling or working abroad clearly operate under special circumstances not experienced in the domestic insurance market and should be candidates for relief from MLR regulations.

We hereby request that the NAIC recommend to the U.S. Department of Health and Human Services an exemption from Section 2718 for health plans that serve individuals living, working, studying or traveling abroad, because of the plans':

- Lower premiums
- Higher distribution costs
- Higher loss-adjustment and case management expenses
- Volatile and challenging cases serviced on a global basis
- Additional high cost member services and tools

In the alternative, at a minimum, we request that the NAIC recommend the establishment of significantly lower MLRs that take into account the special circumstances of health plans for individuals traveling, living or working abroad and a special methodology for global plans that permits the inclusion of our higher costs that are inextricably linked to providing immediate medical care abroad as clinical costs in the MLR. Furthermore, we agree with the comments submitted to NAIC by others that the term "clinical services" should be based on NAIC's definitions of claims and claims-related expenses in its various statutory accounting standards as permitted medical costs, and, should include: 1) reimbursements to health care providers; 2) payments to third parties; 3) other categories of provider payment; and 4) incurred-loss plus loss adjustment expenses (as enumerated in SAP 85).

Because HTH is a specialty insurance provider which only provides products and services to international travelers and expatriates, we do not have the capability to blend or offset our higher administrative costs with domestic business where these costs are lower. Placing us under the same MLR restrictions as domestic plans could make these products unaffordable, unsustainable and uncompetitive in the global marketplace. Consequently, it is of utmost importance to us that NAIC use their discretion to take into account special circumstances of different types of plans such as plans offering coverage to individuals traveling, living, studying or working abroad.

We appreciate your serious consideration of our unique circumstances and the valuable role global health plans play in the insurance market. We would be happy to discuss this with you further and to provide you with additional information on our plans and plan expenses.

Sincerely,

A handwritten signature in black ink, appearing to read 'AM', with a long horizontal flourish extending to the right.

Angelo Masciantonio  
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