March 14, 2011

Submitted via electronic mail to tmullen@naic.org

Hon. Kevin M. McCarty
Insurance Commissioner, State of Florida
Chairman
Professional Health Insurance Advisors (EX) Task Force
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 701
Washington, DC 20001

Re: Invitation to Comment on Draft Legislation Designed to "Preserve Consumer and Employer Access to Professional Health Insurance Advisors"

Dear Commissioner McCarty and Task Force Members:

Aetna welcomes the opportunity to respond to the invitation of the Professional Health Insurance Advisors (EX) Task Force (the "Task Force") of the National Association of Insurance Commissioners ("NAIC") regarding draft legislation to "Preserve Consumer and Employer Access to Professional Health Insurance Advisors" (the "Draft Legislation") by amending relevant sections of the Patient Protection and Affordable Care Act ("ACA").

Aetna is one of the nation's leading diversified health care benefits companies, providing members with information and resources to help them make better informed decisions about their health care. Our programs and services strive to improve the quality of health care while controlling rising employee benefits costs. Aetna offers a broad range of traditional and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life, long-term care and disability plans and medical management capabilities.

Aetna endorses the Draft Legislation and agrees that broker compensation should be removed from MLR calculations. The National Association of Health Underwriters ("NAHU") believes without this modification, the MLR will "destroy the ability of agents and brokers to work with individuals and small employers as they evaluate and purchase health insurance... [and] many of these individuals and small employers will go without health insurance coverage...".[1]

NAHU also notes that a pass-thru is consistent with the NAIC approach of excluding from insurance premium revenue items that are not actually compensation to an insurer (*e.g.,* taxes). According to NAHU, "Viewed in this light, agent commissions are actually the revenue of the agent and should not be included in health insurers premium revenue for the purpose of calculating minimum loss ratios."[2]

In Aetna's view, the Draft Legislation also offers NAIC an opportune foundation for addressing key additional MLR shortcomings – most notably the treatment of fraud prevention, ICD-10, utilization management, the large group market, and rebate administration. In addition, the current IFR creates additional incentives for employers to self-fund their coverage. Currently, only 12% of employers size 3-99 self-fund with about 53% of employers size 200-999 self-funding. The current MLR is likely to drive an increase in these numbers.

A. MLR should exclude broker services

In today's marketplace, brokers provide important services to consumers and employers of all sizes. For small and mid size employers, they perform functions that the human resources department would provide for much larger employers. Nationally, about 71%[3] of employers offering coverage used agents and brokers to purchase such coverage and 36%[4] of individuals purchase coverage using a broker.

Health insurance is a significant – and important investment --- for any consumer or employer. Different consumers have different needs and their selection of products will have an impact on their future choice of providers, their total out-of-pocket costs and other important items. In today's voluntary market, many individuals choose to bypass this important investment and take the "risk" associated with lack of coverage. 30.4 percent of individuals age 18-24 were uninsured and even 29.1% of individuals 25-34 were uninsured in 2009.[5] Over 40 percent of employers with 3 to 10 workers still do not offer coverage.[6] Brokers help explain the important reasons that individuals and employers should purchase insurance, and more importantly they help them shop for coverage among multiple options available in the market.

According to a report by the Center for Studying Health System Change:

> "… an examination of the role of brokers in 12 nationally representative communities… indicated that brokers provide valuable services to small firms, such as obtaining prices for coverage, explaining benefits to employees and problem-solving for employers. In some markets, brokers also helped educate employers and employees about state policy initiatives to expand coverage. In contrast to the notion that brokers merely make insurance more costly, these findings suggest brokers can provide important benefits to small employers, plans and policy makers."[7]

Many of those educational sessions still result in consumers choosing to "go uninsured." Typically, an agent must write multiple quotes for every policy actually sold – meaning an agent may earn less than $10 to $20 per month for every quote written. When a policy is sold, agents provide service on those policies, helping customers with claims or other questions, and serving as their customers' advocate if problems arise.

Customers clearly recognize this value-added role that brokers and agents play on their behalf. A survey of 1,000 American consumers found an overwhelming preference for personalized service and human interaction from their insurance producers, and that three-quarters of consumers are very satisfied with the service provided by their agents and remain committed to working with them in the future. More than half (53%) of consumers cite personalized service as what they like best about the services offered by their insurance agent, and quality of service topped the list of the key factors in choosing an insurance provider.[8]

The proposed NAIC changes to the MLR would help facilitate continued relationships between brokers and consumers and we support this initiative.

B. States need flexibility in the individual and small group markets

Aetna is also pleased the Task Force decided to include in its Draft Legislation additional important MLR amendments, even though these do not directly relate to the treatment of brokers and agents.

Specifically, Aetna agrees with the Task Force that the small group and individual markets would be well served by the Task Force's proposal to widen application of Secretarial discretion to adjust the ACA's MLR percentages to the small group market. We concur that the current ACA provision should apply such authority not only to the fragile individual markets, but also to the vulnerable small group segment as well. The current IFR will result in consumers and employers in many states losing their coverage and precluding their ability to "keep what you have." Only six states currently have MLR rebate requirements – and only half of these are at least 80%.[9] This is a major change for the marketplace in the vast majority of states.

We also would note that states -- especially those with smaller insurance departments -- may struggle to provide the breadth of data that the Department of Health and Human Services ("HHS") currently is requesting as part of these waiver requests. To ease the burden on these states, we believe NAIC should recommend that the Secretary offer transition MLR rules for any state to use. These rules would allow states to transition their markets from 70% (2012), 75% (2013) and to 80% (2014). States also should be allowed to request special waivers with lower thresholds if their market would still be destabilized.

The large group market also would benefit from transition rules. It is even rarer for states to require rebates with regard to large group market MLRs than for the individual and small group market. This, combined with the imposition of state-by-state rules on an interstate large group market, is likely to lead to disruption in the large group market.

C. NAIC Should Take Opportunity to Address Wider MLR Shortcomings

NAIC has taken a necessary and important step in its creation of the Task Force and its development of the Draft Legislation to address MLR shortcomings regarding broker compensation and flexibility in the face of threatened market instability. However, these are far from the only serious threats to markets and consumers posed by the MLR IFR requirements.

As time elapses from the initial IFR issuance, increasingly policymakers and employers are seeing the potential loss of choice and competition in the marketplace. NAIC, acting in its respected capacity as the collective voice of the country's insurance regulators, should recommend additional corrections of critical issues.

We believe that some of the most urgent MLR-related priorities include:

1) *MLR requirements should not discourage efforts to combat fraud.* Fraud is estimated to account for at least 3%—or roughly $70 billion—of total U.S. health care spending per year. Insurers normally invest in fraud prevention and state

and federal authorities benefit from collaboration with the private sector. The federal MLR counts preventive fraud expenses against insurers, because such expenses are excluded from the government-specified activities on which insurers can expend premium dollars without potential penalty.

2) *ICD-10 expenses should be included as "quality improvement activities."* Conversion to ICD-10 will improve quality in numerous ways, including enhanced clinical research and improved disease management. Implementation costs associated with ICD-10 should be classified as a "quality improvement activity" with respect to MLR calculation.

3) *Concurrent review and utilization management.* Concurrent review assures the best site for care (intensive care unit, rehabilitation facility, etc.) and can identify additional intervening quality issues. For example, a concurrent review could identify that a hip surgery inpatient has not yet begun physical therapy, and would alert the physician to that problem. Retrospective utilization management programs play a critical role in furthering evidence-based medicine in the provider community. This helps assure that providers are educated about providing the right care at the right time, and will improve the quality of care over time.

4) *National aggregation in the large group market.* Requiring insurers to disaggregate their large group market into state MLRs, and to separately report HMO and PPO MLRs will undermine the vibrant and efficient marketplace now available to large employers. Specifically, it will erode competition, reduce product choice and ultimately result in higher premiums for large employers. The ability of employers to offer employee choice (HMO vs. PPO) will be threatened and some employees will not be able to "keep what they have." It also is important to note that requiring MLR rebates in the large group market is virtually unheard of at the state level. This will be a significant change for most states and will be especially difficult for those states with smaller populations.

5) *Clarifying that rebates should be returned to employers.* The IFR imposes a complex rebate administration process. In many cases, insurers will expend more on the administration of rebates than on the rebates themselves. Insurers do not have the information necessary to refund rebates to employers – and our employer customers do not want to assume the added costs of these significant administrative responsibilities.

6) *Pooling of affiliated licensed entities for individual and small group markets.* Insurers are often required to sell HMO and PPO business from separate, affiliated licensed entities within a state. If insurers are not able to pool this business together for MLR, then they will not be able to pool the risk together for pricing. To create larger risk pools, insurers must be able to aggregate affiliated licensed entities for MLR calculations.

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Aetna is pleased to have the opportunity to provide comments regarding the NAIC Task Force Draft Legislation concerning broker compensation and other amendments to ACA MLR requirements. Thank you for considering our comments. Should you have any questions, please feel free to contact me.

Sincerely,

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[1] November 12, 2010 Letter from National Association of Health Underwriters (NAHU) to Secretary Sebelius

[2] November 12, 2010 Letter from National Association of Health Underwriters (NAHU) to Secretary Sebelius

[3] http://www.411sbfacts.com/sbpoll.php?POLLID=0058

[4] http://www.kff.org/kaiserpolls/upload/8077-R.pdf

[5] Income, Poverty, and Health Insurance Coverage in the United States, 2009, U.S. Census Bureau http://www.census.gov/prod/2010pubs/p60-238.pdf

[6] Kaiser HRET 2010 Survey http://ehbs.kff.org/pdf/2010/8085.pdf

[7] Leslie Jackson Conwell, "*The Role of Health Insurance Brokers – Providing Small Employers with a Helping Hand*," Center for Studying Health System Change, Issue Brief No. 57 (2002), http://www.hschange.com/CONTENT/480/ .

[8] "*Three-Quarters of Insured Americans Are Satisfied with Their Insurance Agent and Remain Loyal*." Survey commissioned by IBM, May, 2007. Accessed at: http://www-03.ibm.com/press/us/en/pressrelease/21583.wss

[9] State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations (as of April 15, 2010)