October 20, 2010

Commissioner Jane Cline
Members, NAIC Executive Committee

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide the National Association of Insurance Commissioners (NAIC) with comments and recommendations in response to the NAIC draft "Regulation for Uniform Definitions and Standardized Rebate Calculation Methodology for Plan Years 2011, 2012 and 2013 Per Section 2718 (b) of the Public Health Service Act." During the health care reform debate, the AMA repeatedly expressed support for establishing greater transparency in the health insurance market. Transparency of health insurance and medical loss ratio information is extremely valuable for patients and the AMA supports patients receiving the maximum value for the premium they pay. Mandating a medical loss ratio and that health insurance premiums be spent on direct medical care is essential to ensuring that patients receive the value for the health care benefits that they pay for.

We support the medical loss ratio draft regulation adopted by the B Committee on October 14, 2010. We urge you to not change this adopted version, which reflects significant compromise and process. Moreover, we oppose amendments supporting national aggregation, inclusion of broker and agent fees in the loss ratio and increasing the confidence interval to 80 percent. We urge you to adopt the same version adopted by the B Committee on October 14, 2010. We have concerns about the following issues.

Oppose increasing the confidence interval, retain approved 50 percent level

We urge you to retain the current 50 percent confidence level rather than increasing it to 80 percent. If the confidence level is increased, the incentive for insurers to price below 80 percent (and to become more efficient) will be removed, promoting unfair and inconsistent pricing. For example, insurers with limited amounts of business in a state (below 10,000 covered lives,) would eliminate the risk of ever paying a rebate. Insurers are well aware of the fluctuation in results for their markets each year. As a result, insurers rarely set their rates to a level that they are 90 percent confident that they will not incur loss. Insurers are more likely to price to the 50 percent confidence level because it is reasonable and does not result in excessive adjustments to the calculated medical loss ratio with the credibility adjustment. The 50 percent confidence level is also more consistent with the confidence intervals currently used in the initial pricing used by insurers.

The current regulation treats both insurers and consumers fairly with the 50 percent confidence level. We urge you to retain this fair confidence level to ensure that the intent of ACA is met. Increasing the level to 80 percent will undermine the purpose of ACA and remove the pressure on insurers to meet the 80/85 medical loss ratio threshold. If the confidence level is increased so significantly, only minimal rebates will be paid to consumers with such great room for fluctuation. As a result, insurers have a lot of room to inaccurately estimate their level and no incentive to be efficient.

The medical loss ratio will force insurers to change the way they do business, including becoming more efficient and using a fair and more limited amount of premium for administrative expenses- leaving maximum dollars for patient care. Rather than increasing the interval confidence rating, we urge you to require insurers to better evaluate the opportunities they have in each state and/or market and determine if they can competitively market their product there or not. The net result is lower rates for consumers and better insurer pricing.

Retain state level aggregation

We oppose the amendment to allow for national aggregation. Health insurers have been regulated by state insurance departments for many years. Health insurer rates are set at the state level. The current draft regulation allows for aggregation at the state level and we urge you to retain this requirement. National insurers can comply with this law and already comply with state insurance department requirements every day. For example, national insurers with licenses in multiple states have similar financial statements for every state and comply with multiple state laws. National insurers also comply with state policy filing and rate filing requirements. When national insurers submit financial statements to state insurance departments, they send both state specific and national level information. Requiring insurers to comply with state level aggregation not only most accurately reflects accurate marketplace and regulatory requirements, but is already common practice. Health insurers are already accustomed to sending national data to state insurance departments.

Allowing for national aggregation will also negatively impact consumers ability to receive the medical loss rebates that they are entitled to under ACA. The medical loss ratio and resultant rebate is best administered at the state level because it will streamline finding the rebate recipients. Rates are determined by states (in fact by metropolitan areas within a state). If allowed to aggregate on the national level, insurers can tweak the medical loss ratio to avoid rebates. For example, an insurer could have an 85 per cent medical loss ratio nationally (and thus would not owe a rebate), but if this calculation was drilled down by state, the insurer may own many affiliates with smaller medical loss ratios, which, if calculated by state and entity,

would owe rebates. Rather than robbing dollars from consumer rebates, insurers should follow the intent of ACA and manage their administrative expenses to ensure that they operate at the appropriate level of premium to expense to minimize the chances of paying rebates. We urge NAIC to retain the current state level aggregation to ensure that the intent of ACA is followed, and that consumers receive the value for the premium that they pay.

We do not agree that without national aggregation, insurers will be forced to leave the market in states with low medical loss ratios. It is more likely that they will leave a state with a higher medical loss ratio (such as 85 percent), because they make less profit. Retaining the current state level aggregation will improve the marketplace because insurers will be forced to better price their products, remain competitive, provide better networks and provide consumers and providers with accurate and transparent health benefit information.

Oppose including broker fees in the loss ratio

We strongly oppose excluding broker fees and commissions from the earned premium calculation. The law does not allow for inclusion of these fees and commissions to be included. The damage to consumers will be significant. This will dramatically increase the amount that the insurers could consume for administrative expenses and profits. Under the law insurers can spend 15 or 20% on these costs. If they don't have to pay agent commissions, which could be 3 to 5% or more, they can retain more profit. Second, agent and brokers would still need to be paid, and their commissions would now be added to the premium. Consumers will pay the price.

Conclusion

The AMA appreciates the opportunity to provide its comments about medical loss ratios to NAIC. We look forward to working further with NAIC and HHS on this important matter. Should you have any questions regarding these comments, please contact me at elizabeth.schumacher@ama-assn.org or (312) 464-4783 for more information.

Sincerely,

Elizabeth A. Schumacher
Legislative Attorney
Advocacy Resource Center

To: Jane Cline, President NAIC, and Executive Committee and Plenary
Sandy Praeger, Chair B Committee

Fr: Timothy Jost

Re: Producer's Commissions in the MLR

Date: 10/19/2010

As we are hearing that this issue has come up again, we would like to emphasize again that the statute simply does not permit removing producer's commissions from the MLR, a point recognized by the executive and plenary in Seattle when it included them in the premium for the rebate calculation and at several places in the proposed regulation. We addressed this issue at length in our comments to the B Committee, which are attached here:

- We support the decision of the NAIC, reached unanimously in Seattle, and incorporated into the regulation, to include producers' commissions as part of the premium and as administrative expenses. It is clear that Congress intended agent/broker commissions to be counted as administrative costs for purposes of the MLR. On December 20, 2009, hours before the Senate passed PPACA, Senator Nelson, the former insurance commissioner of Florida, explaining how the legislation made health insurance more affordable, stated on the Senate floor:

  > I want to give one specific example. It is a technical term in the insurance industry called the "medical loss ratio." It is the ratio in what an insurance company actually pays out in medical claims as opposed to what it pays for administrative expenses such as marketing, insurance agent commissions, underwriting, and an insurance company's profit. . . . What this amendment . . . says, is it causes a specific ratio so you are getting a high amount of return on the insurance premium dollar.. . . .And the balance, . . . is going to things such as administrative expenses, paying for insurance agents, commissions, paying for their profit…

  155 Cong. Rec. S13558, S13626-S13627.

  Moreover, the clear wording of ACA precludes the exclusion of commissions. Section 2718(a)(3) discusses, "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." If Congress wanted to exclude commissions from "all other non-claims costs" they could have done so. The fact that Congress did not, while excluding other items, clearly shows that for purposes of the MLR calculation, commissions must be treated the same as any other non-claims cost.

  Section 1301(a)(1)(C)(iii) of the ACA states that the issuer of a qualified health plan must agree "to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or

whether the plan is offered directly from the issuer or through an agent." Obviously Congress understood that agent/broker commissions were part of the premium rate charged by health insurers. We support the NAIC in maintaining this position.

Excluding commissions from premiums would also dramatically increase the portion of the premium available to insurers for their other administrative costs. Congress set the target MLR percentages at 80 percent for the individual and small group market and at 85 percent in the large group market, and the CBO accepted these percentages, under the assumption that producer commissions were included. It would have set the percentages higher had it assumed they were excluded. Moreover, insurers have throughout the Subgroup process assumed producers' commissions were included in the MLR. It is the primary reason why they have argued that transitional adjustments to the MLRs are necessary.

Treating commissions the same as the other overhead expenses of insurance companies is consistent with the manner in which financial statements are required to be submitted to the NAIC. In the Annual Statement filed by Life Insurance Companies, in both the Summary of Operations (Page 4) and the Analysis of Operation by Lines of Business (Page 6), commissions (Lines 21 and 22) are treated in exactly the same manner as general expenses (Line 23) in determining the net gain from operations (Line 29). Hence, the NAIC has previously made the determination that for the purpose of financial reporting and analysis, commissions should be treated in the exact same manner as any other insurance company overhead expense. This same procedure should be used for financial reporting and analysis in the MLR calculation.

Agents and Brokers have argued that commissions are a pass-through fee and hence should not be included in the MLR calculation. That argument is completely without merit. From the point of view of the consumer, it does not matter what entity ends up with a portion of the premium. The issue to the consumer, and to Congress, is how much of the premium goes toward "reimbursement for clinical services provided to enrollees under such coverage [and] for activities that improve health care quality". Commissions simply do not fall into either of those categories. It should also be remembered that agents work for insurance companies. Furthermore, for many consumers, there is no difference between the agent and the insurance company. They are considered the same entity.

Finally, it is generally accepted in the insurance industry that commissions are part of premiums. The National Association of Health Underwriters website gives the following definition of Commission[1]:

> **Commission:** Part of an insurance premium, which is paid by an insurance company to an agent or broker for procuring and

[1] http://www.nahu.org/consumer/glossary.cfm#C

servicing the business for the insurance company/client. Depending upon the size of the group being insured, these commissions average between three and ten percent of the premium paid by the employer.

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Date: October 16, 2010

To: Larry Bruning, Chair Life And Health Actuarial Task Force

From: Allan I. Schwartz, on Behalf of the NAIC Consumer Representatives

Re: Comments on the Medical Loss Ratio Regulation

I am writing in regard to the Medical Loss Ratio Regulations as adopted by the Health Insurance and Managed Care (B) Committee on Oct. 14, 2010; as well as the conference call on the same day. The areas I will address are:

1. Aggregation
2. Credibility
3. Contract Reserves
4. Prior Rebates

For each of these items, I believe the proper approach was set forth in the regulation submitted to the (B) Committee, before amendments. The basis for this is discussed in the remainder of this memo.

1. <u>Aggregation</u>

The issues of aggregation were among the earliest IRDs resolved by the Accident & Health Working Group – PPACA Subgroup.

IRD002, resolved June 28, states, "For purposes of MLR calculations, each 'statutory entity' (licensed carrier, such as insurer, HMO, or service corporation) should have a separate rebate calculation. Experience of affiliated carriers should not be combined for rebate calculation purposes." [1] IRD003, resolved June 7, states, "Aggregation is by state".[2] Both IRD002 and IRD003 were correctly resolved.

[1] The Documentation for IRD002 states, "The law refers to a 'health insurance issuer' in discussion of the requirement for rebates. There does not seem to be any discussion or interpretation which settles whether this term refers to a statutory entity or to an affiliated group of companies. Although this is more a legal than an actuarial question, ***it is probably appropriate to think that health insurance issuer is to be understood as the legal entity itself (which is the entity that has the authority to issue coverage) rather than an affiliated group of carriers***." (Emphasis supplied)

Health insurance rate regulation is performed at the state level, separately for each insurance company. The expected MLRs are a direct function of the rate process. The logical basis for calculating MLRs is on the same basis by which health insurance rates are determined, which is by state and insurance company.

For a policyholder, the issue of whether they receive value for their premium payments is related to the rates charged by the insurance company they purchased coverage from, and is not dependant on rates charged by another insurance company even if that other company is in some way affiliated with their insurer.

During 2009, Golden Rule Ins Co, a company in the United Health Group, had a loss ratio for individual business of 65.4% with earned premium of $207 million and covered lives of 114,110.[3] Will policyholders who purchased individual coverage from Golden Rule be satisfied with an explanation that they did not receive a rebate (or received a vastly reduced rebate) because of the overall individual business loss ratio for United Health Group?[4]

The same situation occurs in the group market. During 2009 Golden Rule Ins Co had a loss ratio for group business of 62.7% with earned premium of $1.12 billion and covered lives of 514,503.[5] Will policyholders who purchased group coverage from Golden Rule be satisfied with an explanation that they did not receive a rebate (or received a vastly reduced rebate) because of the overall group business loss ratio for United Health Group?[6,7]

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[2] The Evaluation for IRD003 states, "There appears to be general acceptance that geographical aggregation should be at the state level. Currently, insurance is regulated at a state level, resulting in different policy and rating provisions between states. Counter-arguments generally address the potential lack of credible size at the state level and the difference in administration associated with multi-state large carriers. Compelling guidance is provided by the principle that the consumer should see experience developed from a specific policy available for purchase. To reflect experience from a policy issued in another state and unavailable to the consumer does not seem reasonable. Generally the burden of making appropriate adjustments should lay with the carrier not the consumer."

[3] NAIC 2009 Accident and Health Policy Experience Report, Page 47. These are countrywide values. Figures by state were not available.

[4] During 2009, United Health had an overall loss ratio (excluding expenses for activities that improve health care quality) of 82.3% for individual business.

[5] NAIC 2009 Accident and Health Policy Experience Report, Page 129. These are countrywide values. Figures by state were not available.

[6] During 2009, United Health had an overall loss ratio (excluding expenses for activities that improve health care quality) of 82.5% for group business.

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Similarly, from a policyholder perspective, the rates charged in another state have no relation at all to whether that policyholder received value for the premium payments made in their particular state.

During 2009, Humana Health Ins Co of Florida, a company in the Humana Group, had a loss ratio for individual business of 68.8% with earned premium of $156 million and covered lives of 82,586.[8] Will Florida policyholders who purchased individual coverage from Humana Health Ins Co of Florida be satisfied with an explanation that they did not receive a rebate (or received a vastly reduced rebate) because of the overall individual business loss ratio for United Health Group on a countrywide basis?[9]

Taking these considerations into account, the appropriate level of aggregation is: (i) at the "statutory entity" level and not on an affiliated group basis and (ii) at the state level and not the national level. The level of aggregation in the proposed regulation is proper and should not be changed.

2. Credibility

The proposed regulation, in using a 50% confidence interval credibility adjustment, strikes an appropriate balance between insurance companies and policyholders. Moving to an 80% or 90% confidence interval would tilt the results strongly in favor of insurance companies and against consumers.

Using an 80% or 90% confidence interval would essentially guarantee that only minimal rebates would be paid to insurance consumers. This can be seen from the following table prepared by the American Academy of Actuaries.[10]

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[7] The situation would be even more egregious for group policyholders in Pacificare Life & Health Ins Co (also a company in United Health Group), where the loss ratio in 2009 was 43.2% for group business, based upon earned premiums of $263 million and covered lives of 545,649.

[8] NAIC 2009 Accident and Health Policy Experience Report, Page 49. These are countrywide values. Figures by state were not available.

[9] During 2009, Humana Health Group had an overall loss ratio (excluding expenses for activities that improve health care quality) of 81.4% for individual business.

[10] The table shows the expected MLR after rebate percentage to 2 decimal places. It appears the AAA has to do this because the impact of rebates is so tiny at the 90% confidence interval that the impact would disappear if the results were shown to the nearest 0.1%.

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Impact of Credibility Adjustment Based on Assumption of Pricing at an 80% MLR

Average Members	Credibility Adjustment to MLR			Expected MLR After Rebates			
	50% CI	80% CI	90% CI	50% CI	80% CI	90% CI	None
200,000 & over	0.7%	1.3%	1.6%	80.12%	80.03%	80.01%	80.32%
100,000 - 199,999	1.0%	1.8%	2.3%	80.19%	80.05%	80.02%	80.54%
75,000 - 99,999	1.1%	2.1%	2.6%	80.22%	80.06%	80.02%	80.64%
50,000 - 74,999	1.4%	2.6%	3.2%	80.28%	80.07%	80.02%	80.81%
25,000 - 49,999	1.9%	3.7%	4.6%	80.37%	80.09%	80.02%	81.08%
15,000 - 24,999	2.5%	4.7%	5.9%	80.47%	80.11%	80.04%	81.43%
10,000 - 14,999	3.1%	5.8%	7.3%	80.58%	80.13%	80.03%	81.73%
5,000 - 9,999	4.3%	8.2%	10.3%	80.73%	80.14%	80.04%	82.41%
2,500 - 4,999	6.2%	11.7%	14.7%	80.93%	80.16%	80.04%	83.39%
1,000 - 2,499	9.6%	18.3%	22.9%	81.27%	80.14%	80.02%	85.00%
500 - 999	13.6%	25.8%	32.4%	81.28%	80.04%	80.00%	87.41%
Under 500	NA	NA	NA	NA	NA	NA	NA
Average				80.59%	80.09%	80.02%	82.25%

Source: May 20, 2010 memo from Rowen Bell to Steven Oslund, Page 3

With a 90% confidence interval, the expected MLR after Rebates reaches a maximum MLR value of 80.04%, just 0.04% above the 80% minimum loss ratio in PPACA; and an average MLR value of 80.02%, just 0.02% above the 80% minimum loss ratio in PPACA.

With an 80% confidence interval, the expected MLR after Rebates reaches a maximum MLR value of 80.16%, just 0.16% above the 80% minimum loss ratio in PPACA; and an average MLR value of 80.09%, just 0.09% above the 80% minimum loss ratio in PPACA.

These tiny average MLR rebate increments of 0.02% and 0.09% above the 80% minimum loss ratio in PPACA show that at either an 80% or 90% confidence interval, the possibility of a rebate is small and the amount of any such rebate will also be small. This happens because the credibility adjustment factors are so large when using either an 80% or 90% confidence interval. The end result of using either an 80% or 90% confidence interval credibility adjustment is to effectively emasculate Section 2718 (b), “Ensuring That Consumers Receive Value For Their Premium Payments”.

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With a 50% confidence interval, the expected MLR after Rebates reaches a maximum MLR value of 81.28%, with an average MLR value of 80.59%.[11] Hence, the cost to insurance companies of using a 50% confidence interval for the MLR rebate calculation is on average only about 0.6% of premium. Even for small insurance companies, with 1000 covered lives, the impact is only slightly above 1% of premium. This clearly demonstrates that the use of a 50% confidence interval credibility adjustment factor is hardly the disaster that insurance companies have been proclaiming.

The use of the 50% confidence interval credibility adjustment eliminates about 74%[12] of the impact of the minimum loss ratio of 80%. The use of an 80% or 90% confidence interval credibility adjustment would eliminate about 96%[13] or 99%[14] of the impact of the minimum loss ratio of 80%, respectively. The 80% and 90% confidence interval credibility adjustments eliminate such a huge portion of the impact of the 80% minimum loss ratio as to essentially render ineffective that provision in PPACA.

Furthermore, it should be remembered that the AAA analysis was based upon the assumption of pricing to an 80% loss ratio. If insurance companies price to a loss ratio lower than 80%, then the MLR calculation will result in insufficient rebates being given to policyholders.[15,16]

In summary, using the 50% confidence interval credibility adjustment strikes an appropriate balance between insurance company and consumer interests, while having only a small expected financial impact on insurance companies.

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[11] The average value shown is a simple average of the loss ratios by "average members" grouping. We were not able to perform a premium weighted average since we did not have the premium distribution by grouping. However, the larger groups can be expected to have larger premiums, and since the expected loss & rebate ratios decrease as the group size increases, the premium weighted average ratio can be expected to be lower than the simple average ratio. Hence, the loss & rebate ratios, along with the corresponding rebate impact, shown in this memo are overstated.

[12] 74% = [(80.59% - 80.00%) / (82.25% - 80.00%) – 1] X 100%

[13] 96% = [(80.09% - 80.00%) / (82.25% - 80.00%) – 1] X 100%

[14] 99% = [(80.02% - 80.00%) / (82.25% - 80.00%) – 1] X 100%

[15] See June 30, 2010 memo from Allan I. Schwartz to Steven Oslund

[16] Even if a rate filing indicates that the pricing target is 80%, the actual pricing target could be lower than 80% if the loss provision in the filing is inflated by the use the excessive reserves, overstated loss trend factors or other factors (e.g., deterioration) applied to the losses.

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In contrast, using either an 80% or 90% confidence interval credibility adjustment would significantly favor insurance companies over consumers, and the result would effectively eviscerate the rebate provision of PPACA by making rebates very infrequent and small in size.

The credibility procedures in the proposed regulation are proper and should not be changed.

3. Contract Reserves

The issue of contract reserves was also resolved very early in the process. IRD008, resolved June 28, states, "Contract reserves should be defined as described in the Accounting Practices & Procedures Manual (APPM) for entry in the statutory financial statements".

It appears that the insurance industry wants to be able to use contract reserves different than those used for the statutory financial statement. Such a procedure would be improper for several reasons.

First, giving insurance companies the opportunity to calculate contract reserves using various assumptions and procedures would open the door to manipulate the reserves in such a manner to obtain a distorted MLR that would eliminate or greatly reduce any rebate. Such a procedure would frustrate the intent of PPACA that "Consumers Receive Value For Their Premium Payments".

Second, insurance company officers certify under oath that the values shown in the statutory annual statement are correct.[17] The NAIC also requires a Statement of Actuarial Opinion dealing with reserves. To permit insurance companies to use one value for the reserves for the statutory annual statement, and another value for reserves for the MLR calculation would allow insurance companies to eliminate or minimize rebates, and is a textbook example of "two sets of books". Allowing insurance companies to use different contract reserves for the MLR calculation than the reserves determined in accordance with the APPM for statutory financial statements would undermine public confidence in the entire process.

The treatment of contract reserves in the proposed regulation is proper and should not be changed.

4. Prior Rebates

The B Committee adopted a revision to the regulation as proposed by the Accident & Health Working Group – PPACA Subgroup and the Life And Health Actuarial Task Force. That revision, which incorporates prior rebates in the MLR calculation is improper and should be reversed. The problem with the revision can be seen most easily with a simple example.

For the purpose of the example we will assume that an insurance company has fully credible experience each year from 2011 to 2013, and that the loss ratio before rebates in each year is 70% and that the minimum loss ratio standard is 80%. Given that the insurance company's experience is fully credible, then the rebate should be 10% of premium each year, and the insurance company should have an overall loss ratio after rebates of 80%. However, as shown in the following table, that does not occur with the revision adopted by the B Committee. While the loss ratio after rebate is 80% in both 2011 and 2012, in 2013 when the prior rebates are considered, the loss ratio after rebates is only 73.3%. This clearly demonstrates that the revision adopted by the B Committee gives an improper result.

[17] The statutory annual statement includes the following wording, "The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of the said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively."

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Summary of Rebate Calculations for 2011 - 2013 With Fully Credible Experience Each Year
(Amounts in Millions)

Year	2011	2012	2013
Earned Premium Less Taxes & Fees For Year	$500	$500	$500
Earned Premium Less Taxes & Fees For Rebate Calculation	$500	$500	$1,500
Incurred Claims For Year	$350	$350	$350
Incurred Claims For Rebate Calculation	$350	$350	$1,050
Medical Loss Ratio	70.0%	70.0%	70.0%
Prior Rebates	NA	NA	$100
Incurred Claims Plus Prior Rebates for Rebate Calculation	$350	$350	$1,150
Medical Loss & Prior Rebate Ratio for Rebate Calculation	70.0%	70.0%	76.7%
Minimum Medical Loss Ratio	80.0%	80.0%	80.0%
Rebate Indicated for Year	$50	$50	$17
Combined Incurred Claims plus Rebate for Year	$400	$400	$367
Medical Loss & Rebate Ratio for Year	80.0%	80.0%	**73.3%**

Given that the revision adopted by the B Committee gives an incorrect result and substantially understates the rebate for 2013, the change in the proposed regulation should be reversed.

Please feel free to contact me if there is anything you would care to discuss.

October 8, 2011

Commissioner Sandy Praeger, Members of the NAIC B Committee

RE: REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZED REBATE CALCULATION METHODOLOGY FOR PLAN YEARS 2011, 2012 AND 2013 PER SECTION 2718 (b) OF THE PUBLIC HEALTH SERVICE

VIA ELECTRONIC MAIL

Dear Commissioner Praeger, Members of the NAIC B Committee:

The Consumer Representatives to the NAIC, representing millions of patients, consumers and workers, are writing to comment on the Regulation for Uniform Definitions and Standardized Rebate Calculation Methodology for Plan Years 2011, 2012, and 2013 per Section 2718 of the Public Health Services Act proposed by the Life and Health Actuarial Task Force based on the proposal of the PPACA Actuarial Subgroup. We are writing to express our support for the work of the Subgroup, which has worked tirelessly over the past five months to complete this proposed regulation, and to urge adoption of the proposed regulation as written. We have filed numerous detailed comments earlier on many issues raised by the regulation and on issues raised by the Supplemental Health Care Exhibit blank that it incorporates. We assume that you have access to these, but would be pleased to provide you with copies if you do not have them.

We have greatly appreciated the leadership provided by Steven Ostlund and the PPACA Actuarial Subgroup in what has been a long, complicated, and controversial process. We as consumer representatives have spent many dozens of hours on conference calls over the past months and many more hours drafting, circulating, and reviewing comments to be submitted regarding issues raised on these calls. The Subgroup has resolved many contentious and difficult issues over these weeks. The process has consistently been inclusive, participatory, thoughtful, and scrupulously attentive to the intent of Congress in drafting 2718. Mr. Ostlund and the Subgroup members have been unfailingly patient and gracious in helping all participants, including consumer representatives, to understand the positions the Subgroup has taken. They have also been fair and impartial in considering the concerns of all parties involved in the process. Their recommendations were accepted without changes by the Accident and Health Working Group (AHWG) and the Life and Health Actuarial Task Force (LHATF). The Regulation incorporates definitions from the Supplemental Health Care Exhibit blank that in turn were adopted unanimously be the NAIC Executive and Plenary in Seattle after a similarly inclusive, participatory, and thoughtful process conducted by Lou Felice and the Health Reform Solvency Impact (E) Subgroup. We believe that the results of these processes within the NAIC are on the whole reasonable, and urge the NAIC to hold to these decisions.

We would discourage the B Committee from modifying any of the recommendations of the Subgroup and any of the decisions reached by the NAIC Executive and Plenary in Seattle.

Indeed, we believe that the regulations should be accepted as drafted.[1] The Subgroup proposal is a carefully crafted compromise. No one group of interested parties—and certainly not consumer representatives—is completely satisfied with the result or got everything it wanted in the process. We refer you again to our earlier comments which identify issues where the Subgroup rejected our proposals. The Subgroup worked collaboratively, however, to achieve a balanced process. Although individual requests of industry and of other interested parties may seem reasonable on their face, changes in the current recommendations that are not offset by corresponding changes favoring consumers will upset a delicate balance. Such changes would be like pulling a thread from a carefully woven fabric.

As we reach the end of the Regulation drafting process, it may be useful to return to basic principles. Section 2718 of the ACA does not say that insurers are entitled to 15 or 20 percent of premiums (plus their investment income) for their administrative expenses, to which will be added the cost of anything they do that is of value to their enrollees or that pursues a valid health policy goal, including goals endorsed by the ACA. Rather section 2718 says that insurance *consumers* are entitled to have 80 or 85 percent of their premiums spent on clinical health care services, and that the cost of activities that improve health care quality can be counted against that 80 or 85 percent. There are many things that insurers do that are worthwhile and add value for their enrollees and to society. Fighting fraud, controlling costs, discouraging excessive utilization, making certain that providers are qualified, seeking accreditation, coding using ICD-10, and improving public health—these are all valid activities. Indeed, they some are activities that are endorsed at various places in the ACA. But, as the NAIC Executive Committee/Plenary have recognized, Congress defined the "quality improvement activities" that insurers may count against the medical loss ratio in section 2717 of the PHSA. These activities—plus payments for clinical services—are the only activities that section 2718 says can be paid for out of the 80 or 85 percent of premiums allocated to consumers.

Insurers have argued over and over again in these proceedings that these activities should be paid for out of the 80 or 85 percent to which consumers are entitled for clinical services and quality improvement costs At points they even seemed to say that if they had to pay for these activities out of their 15 or 20 percent they would stop doing them. Many of these activities are legally required, others are demanded by employers, others are simply best practices—the mark of a quality health insurance product. But they are not activities that fit within the definition of 2718 or within its purpose, which is to ensure that consumers receive value for their premium payments. The NAIC Executive Committee/Plenary recognized this unanimously at its August meeting. We oppose changes to the regulation that would allow their cost to be counted against the MLR.

We now address specific issues raised in this process:

- We endorse the Regulation's requirement that MLRs be calculated at the entity, state, and market segment (large group, small group, and individual). Indeed, this result is compelled by the ACA. Section 2718 applies to "health insurance issuers." The

[1] Two possible exceptions are the treatment of federal taxes and the definitions of small and large group, which are discussed at the end of this document and also in a separate memo.

PHSA defines "health insurance issuer" to mean "an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance **in a State** and which is subject to State law which regulates insurance."

Moreover, section 2718(b)(1)(A) permits states to set medical loss ratio thresholds at levels above the 80 and 85 percent levels set by section 2718, and provides:

> In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

` It would make no sense to give states discretion as to increasing target percentages if MLRs are to be computed at the national holding company level. Moreover, a clear concern of Congress in adopting section 2718 was that enrollees in states with high MLRs not subsidize inefficient insurers in states with low MLRs. Similarly, there should be no subsidization between different insurance companies or market segments. The result reached by the Subgroup is the result that Congress intended, and should not be changed by the B Committee.

Furthermore, health insurance rate regulation is done at the state level, separately for each insurance company, and also for each market segment (large group, small group, and individual). The expected MLRs are a direct function of the rate process. Therefore, as a practical matter, the logical basis for calculating MLRs is on the same basis by which health insurance rates are determined. The proposed regulation is consistent with the actual procedure for calculating health insurance rates.

- We support the decision of the NAIC, reached unanimously in Seattle, and incorporated into the regulation, to include producers' commissions as part of the premium and as administrative expenses. It is clear that Congress intended agent/broker commissions to be counted as administrative costs for purposes of the MLR. On December 20, 2009, hours before the Senate passed PPACA, Senator Nelson, the former insurance commissioner of Florida, explaining how the legislation made health insurance more affordable, stated on the Senate floor:

> I want to give one specific example. It is a technical term in the insurance industry called the "medical loss ratio." It is the ratio in what an insurance company actually pays out in medical claims as opposed to what it pays for administrative expenses such as marketing, insurance agent commissions, underwriting, and an insurance company's profit. . . . What this amendment . . . says, is it causes a specific ratio so you are getting a high amount of return on the insurance premium dollar.. . . .And the balance, . . . is going to things such as administrative expenses, paying for insurance agents, commissions, paying for their profit…

155 Cong. Rec. S13558, S13626-S13627.

Moreover, the clear wording of ACA precludes the exclusion of commissions. Section 2718(a)(3) discusses, "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." If Congress wanted to exclude commissions from "all other non-claims costs" they could have done so. The fact that Congress did not, while excluding other items, clearly shows that for purposes of the MLR calculation, commissions must be treated the same as any other non-claims cost.

Section 1301(a)(1)(C)(iii) of the ACA states that the issuer of a qualified health plan must agree "to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent." Obviously Congress understood that agent/broker commissions were part of the premium rate charged by health insurers. We support the NAIC in maintaining this position.

Excluding commissions from premiums would also dramatically increase the portion of the premium available to insurers for their other administrative costs. Congress set the target MLR percentages at 80 percent for the individual and small group market and at 85 percent in the large group market, and the CBO accepted these percentages, under the assumption that producer commissions were included. It would have set the percentages higher had it assumed they were excluded. Moreover, insurers have throughout the Subgroup process assumed producers' commissions were included in the MLR. It is the primary reason why they have argued that transitional adjustments to the MLRs are necessary.

Treating commissions the same as the other overhead expenses of insurance companies is consistent with the manner in which financial statements are required to be submitted to the NAIC. In the Annual Statement filed by Life Insurance Companies, in both the Summary of Operations (Page 4) and the Analysis of Operation by Lines of Business (Page 6), commissions (Lines 21 and 22) are treated in exactly the same manner as general expenses (Line 23) in determining the net gain from operations (Line 29). Hence, the NAIC has previously made the determination that for the purpose of financial reporting and analysis, commissions should be treated in the exact same manner as any other insurance company overhead expense. This same procedure should be used for financial reporting and analysis in the MLR calculation.

Agents and Brokers have argued that commissions are a pass-through fee and hence should not be included in the MLR calculation. That argument is completely without merit. From the point of view of the consumer, it does not matter what entity ends up with a portion of the premium. The issue to the consumer, and to Congress, is how much of the premium goes toward "reimbursement for clinical services provided to enrollees under such coverage [and] for activities that improve health care quality". Commissions simply do not fall into either of those categories. It should also be remembered that agents work for insurance companies. Furthermore, for many

consumers, there is no difference between the agent and the insurance company. They are considered the same entity.

Finally, it is generally accepted in the insurance industry that commissions are part of premiums. The National Association of Health Underwriters website gives the following definition of Commission[2]:

> **Commission:** Part of an insurance premium, which is paid by an insurance company to an agent or broker for procuring and servicing the business for the insurance company/client. Depending upon the size of the group being insured, these commissions average between three and ten percent of the premium paid by the employer.

- We strongly support the decision of the NAIC, reached unanimously in Seattle and incorporated into this regulation, to not allow issuers to claim their fraud prevention and detection expenses as quality improvement expenses. Including these expenses as quality improvement expenses would be wholly contrary to the language of the statute and the intent of Congress. Congress was fully aware of the importance of combating health care fraud—an entire title of the ACA is devoted to it—but did not allow consideration of fraud expenses in the MLR.

  Insofar as the regulation does allow an offset of fraud prevention expenses against recoveries, we are concerned that insurers not be allowed to claim any money spent on utilization review or claims audits that result in recoveries of overpayments as fraud detection and recovery expenses. We believe that clear definitions are needed to assure that they do not. We urge the B Committee to tighten the definition of fraud.

- We endorse the decision of the NAIC, reached unanimously in Seattle and incorporated into this regulation, to not include the costs of the ICD-10 conversion as a quality expense, but rather to track them for HHS for further consideration in the future. Insurers are changing from ICD-9 to ICD-10 as part of a worldwide change in coding standards, one mandated of providers by CMS. ICD-10 coding may make it easier to track quality activities, but it is fatuous to contend that the change is itself a quality of care activity. Had the ACA never been adopted or not included section 2718, insurers would still be adopting ICD-10.

  Moreover, while the industry talks only about <u>costs</u> of implementing ICD-10, they do not mention (or account for) <u>savings</u>, e.g., in lower payments to providers through better tracking of services actually delivered, reduced ability to "pad" charges, reduced claims paid, fewer fraudulent claims, and more accurate processing of claims and therefore fewer rejected claims. If the insurers had to report their net costs of the conversion, it is likely there would be none. Businesses adopt these types of cost containment activities to lower costs on a net basis.

[2] http://www.nahu.org/consumer/glossary.cfm#C

- We strongly support the decision, reached unanimously in Seattle and incorporated into this regulation, to identify concurrent and retrospective utilization review, provider contracting, and network management costs as cost control and not quality improvement activities. No doubt these activities have some effect on quality. But they are fundamentally administrative activities and should remain classified as such. Insofar as these activities can be identified as case management, disease management, care coordination, or discharge planning activities related to quality they are already covered under the blank.

- We continue to support the decision of the NAIC, reached unanimously in Seattle and incorporated into this regulation, that taxes on investment income not be subtracted from the denominator. Investment income, which for some insurers is a major source of revenue, is nowhere considered in the MLR formula, which only counts premium revenue. It would be grossly unfair to allow insurers to subtract these taxes from their premium revenue while not having to account for the investment income on which these taxes are based. Moreover, section 2718 provides that taxes are excluded from premium revenue. Taxes not attributable to premium revenue cannot be excluded from it, therefore section 2718 prohibits subtraction of taxes on investment income. The industry's argument that the federal tax exclusion extends to all taxes they pay, including taxes on investment income, would seem to mean that the taxes that insurers pay on premiums from other lines of business should also be subtracted from health insurance premium revenue. This simply cannot be what Congress intended. Only taxes on premium revenue should be excluded, not other taxes paid by insurers. (Alternatively, investment income should be considered premium revenue, since its ultimate source is premiums, and be counted in the denominator).

- We continue to support the approach of the NAIC, adopted unanimously in Seattle and made part of this regulation, to handle the addition of new proposals for quality of care expenses by requiring explicit proposals to be approved by the NAIC and certified by HHS. Earlier proposals that would have permitted the addition of new categories without an explicit review process would be unworkable and open to serious abuse.

- We support the decision of the NAIC, reached unanimously in Seattle and incorporated into the regulation, to allow insurers to count the monitoring, measuring and reporting costs that they incur for maintaining accreditation and for reporting HEDIS and CAHPS data as quality improvement expenses, but not accreditation fees. The National Committee for Quality Assurance (NCQA) accreditation, for example is based on six categories of accreditation standards:
    - Quality management and improvement,
    - Utilization management,
    - Credentialing and recredentialing,
    - Members' Rights and Responsibilities,
    - Standards for Members Connections, and
    - HEDIS/CAHPS performance measures.

While HEDIS and CAHPS and quality measurement and reporting facilitate quality improvement, the remaining standards are intended to assure the quality of the insurance product, not of health care. All of the issues accreditation addresses are important to consumers, but not all are related to improving health care. It is appropriate that insurers be able to claim monitoring, measuring, and reporting costs related to accreditation, but it is not appropriate to including accreditation fees as quality improvement expenses.

- We support the Subgroup's approach to dealing with the credibility of reported MLR experience for small insurers. Small insurers offer consumers choice and provide competition for larger insurers. The credibility adjustments applied by the regulation should allow small insurers to continue to offer their products to insurers. It must be recognized, however, that the credibility adjustments are substantial—up to 14 percent[3] for the smallest insurers—and will be applied to virtually all insurers in many states. It is important, therefore, to underscore the following:
    - The credibility adjustments should not unduly inflate the reported MLR experience of insurers. We therefore would oppose increasing the credibility adjustments above the levels derived by Milliman after extensive analysis and study, which were adopted by the Subgroup.
    - Experience should be carried forward from year to year and rebates should be paid based upon actual reported experience without a credibility adjustment if an insurer consistently fails to achieve the target percentage over a three year period. Otherwise an insurer could consciously aim for a MLR level below the target level and would face no consequences for doing so, contrary to the intent of Congress.[4]
    - MLR rebates in previous years should not be subtracted from the indicated rebate for the current year based upon an aggregation of multiyear experience. The MLR calculation is set up so that each year stands on its own. The process is as follows: for each rebate year (i) an MLR is calculated, (ii) a credibility adjustment, if applicable, is made, (iii) the credibility adjusted loss ratio is compared to the target loss ratio and (iv) to the extent the target loss ratio exceeds the credibility adjusted value, that difference is multiplied by the premium (excluding applicable taxes and fees) for that ***one year*** in order to determine the rebate payable for that one year. Hence, the rebate calculation payable in each year stands on its own[5], and there is no need or basis for subtracting out rebates paid in prior years. While it is possible that other procedures could have been used to calculate rebates, the method set forth in

[3] 14.4% = 8.3% (Table 1 Additive Adjustment) X 1.736 (Table 2 Adjustment Factor)

[4] Technical details discussing how an insurance company that targeted an MLR below the Section 2718(b) levels would pay too low of a rebate are discussed in a June 30, 2010 memo from Allan Schwartz (the actuarial advisor to the Consumer Representatives) of AIS Risk Consultants to Steve Oslund.

[5] Even though the rebate calculation for each year stands on its own, the details of the calculation of the rebate for that one year may reflect the loss ratio experience in other years either because of credibility considerations or the requirements of ACA.

the regulation is reasonable, actuarially sound and should be adopted. The insurance industry may argue that the method in the regulation is biased towards calculating inflated rebates. We strenuously disagree. In fact, in the example presented by NAIC staff[6] in connection with the September 15 Conference Call, the method in the regulation gives a lower rebate than an alternate method where prior rebates are subtracted out. Hence, alternate rebate formulas that are different than those contained in the proposed regulation may sometimes gives a higher indicated rebate and sometimes a lower indicated rebate, but there is no inherent bias one way or another. Finally, Richard Diamond on behalf of the PPACA Actuarial Subgroup of the AHWG, prepared a memo dated September 24, 2010 in which he considered in detail the arguments presented by the insurance industry; and he concluded that the rebate formula in the regulation is appropriate. For all these reasons the NAIC should not change the rebate formula calculation as set forth in the proposed regulation.

- We oppose making further accommodation in the form of exceptions for "different" types of plans in the proposed rule unless the exception is fully justified by the evidence. We recognize that 2718(b) allows the NAIC to "take into account the special circumstances of smaller plans, different types of plans, and newer plans," in establishing the methodology for calculating MLRs. The Subgroup has done so in the credibility adjustments and in dealing with certain employer plans and with new insurers. We understand that mini-med plans would also like to be subject to a different methodology than other plans. We expect other types of insurers will ask for special treatment as well. We would oppose any modification in the methodology that is not supported by hard evidence as to existing MLRs, the special circumstances of particular insurers that make it impossible for them to achieve the MLRs, what adjustment to the general methodology is necessary to accommodate those circumstances and what process will be implemented to move the loss ratio up to (or at least closer to) the Section 2718(b) values. Congress did not intend that this provision be used as a dispensation for granting waivers to plans just because they do not currently meet the MLR requirements.

<u>While we believe that the drafting process should not be reopened, if the B Committee does make any adjustments in the proposed regulation, we would request consideration of the following</u>:

- We urge the B Committee to amend the remainder of the definition of federal taxes to be subtracted from the denominator included in the regulation to conform it to congressional intent. The regulation picks up the broad definition of federal taxes included in the Supplemental Health Care Exhibit. After the Health Reform Solvency Impact subgroup finished its work on this blank, however, the NAIC was informed that in fact Congress intended a much more limited definition of federal taxes, including only the new federal taxes imposed on insurers by the ACA, and not the broad definition included by the Solvency Impact subgroup. Unlike the rest of the

[6] EXCEL File named "MLRRebateFormula0913"

Supplemental Health Care Exhibit, therefore, the tax definition as adopted by the NAIC plenary and included in the regulation was not fully debated through the entire NAIC process with the benefit of full information on congressional intent. The B Committee should, therefore, reconsider this one part of the blank, given the new information. A memorandum from Timothy Jost, examining the language and legislative history of the tax provision in section 2718 is attached. Furthermore, current financial reporting as required by the NAIC recognizes that federal income taxes are separate and distinct from other types of taxes and fees. In the Annual Statement filed by Life Insurance Companies, in both the Summary of Operations (Page 4) and the Analysis of Operation by Lines of Business (Page 6), there are separate lines for "insurance taxes, licenses and fees, excluding federal income taxes" (Line 24) and "federal and foreign income taxes incurred (excluding tax on capital gains) (Line 32). As a first step in determining the "Net Gain from Operations" (Line 29) the financial statement required by the NAIC only subtracts out "insurance taxes, licenses and fees, excluding federal income taxes". It is only later that federal income taxes are removed to obtain a net gain after taxes. Hence, the NAIC has previously made the determination that for the purpose of financial reporting and analysis, that "insurance taxes, licenses and fees, excluding federal income taxes" are separate and distinct from "federal and foreign income taxes" This provides additional support for not subtracting any federal income taxes from premiums in calculating the MLR and corresponding rebate.

- The Rule at section 3.A.(7) & (10) defines small and large group "as such term is defined in the Public Health Services Act." These definitions should be amended to read "as such term is defined in the Affordable Care Act."

  Although section 2718 is a section of the Public Health Services Act, it is added to the PHSA by section 1001 of the ACA, which is part of Title I of the ACA. Section 1551 of the ACA states: "Unless specifically provided for otherwise, the definitions contained in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91) shall apply with respect to this title [Title I]." Section 2791(e) of the PHSA defines large group as group insurance offered by a large employer and small group as insurance offered by a small employer. As amended by section 1563(c)(16) the PHSA defines "small employer" as an employer with 100 or fewer employees and "large employer" as an employer with 101 or more employees. But section 1304 of the ACA specifically provides that for purposes of Title I of the ACA, of which Section 2718 is a part, states may prior to 2016 define small employer to as an employer with 50 or fewer employees and large employer with 51 or more. Since the ACA "specifically provides otherwise," the amended PHSA 2791 definition does not apply.

  The NAIC should adopt the ACA definition, because it is what the law requires, because it increases the discretion of the states to deal with their own particular insurance markets, and because it will avoid the situation of groups between 50 and 100 being classified as large groups for most regulatory purposes but as small groups for the MLR calculations.

Finally, although the handling of the transition to the MLRs between 2011 and 2014 is not addressed by the regulation, it is addressed by the statute, which gives HHS the discretion to reduce the MLRs on a state by state basis as necessary to prevent destabilization of the nongroup market. This issue was addressed by IRD041 which is not part of the final regulation. Transitional problems cannot be addressed through the NAIC's authority to define methodologies, as some have suggested, because the statute expressly delegates to HHS the authority to address this problem. IRD041 presents a viable solution to the problem, however. IRD 041 recommends that the Secretary consult with the Insurance Commissioner in each state (and with consumers, insurers, and other interested parties) to decide whether or not to adjust the 80 percent MLR used for the rebates in one or more years after considering if the application of the MLR is likely to destabilize the state's individual insurance market. It urges HHS to consider other characteristics including the number of carriers and actual historical loss ratios of each individual carrier in the state, alternative sources of insurance coverage, and the vulnerability of the market. We urge the B Committee to ensure that HHS receives IRD041 as a recommendation from the NAIC, independent of the regulation.

Congress asked the NAIC to establish the definitions and methodologies for the MLR process because of the NAIC's technical expertise in insurance matters. The Subgroup has done an exceptional job in applying that technical expertise to the difficult questions raised by the MLR process. Even after the NAIC adopts an MLR regulation, the insurance industry will have the opportunity to request that HHS make changes. Therefore, we strongly urge the NAIC to accept the recommendations of the experts from the various state insurance departments who spent countless hours over many months putting together a document that reflects a technically and actuarially sound implementation of the MLR and rebate aspects of ACA. Adopting the proposed regulations will mean that the NAIC performed the job requested by Congress, which was to use its expertise to draft a technically and actuarially sound regulation. If modifications are made for other reasons, the appropriate place for those changes to be made is at HHS.

We continue to appreciate the care with which you have approached this difficult task and the seriousness with which you have taken our concerns and your responsibility under the ACA.

Sincerely,

Timothy Jost
Georgia Maheras
Stephen Finan
Joe Ditré
Sabrina Corlette
Brendan Bridgeland
Wendell Potter
Mark Schoeberl
Bonnie Burns
Elizabeth Abbott
Butch Hollowell
Barbara Yondorf

To: Commissioner Jane Cline, President NAIC, NAIC Executive and Plenary
Commissioner Sandy Praeger, B Committee Members

Fr: Timothy S. Jost,
Stephen Finan
Barbara Yondorf
Wendell Potter
Stacey Pogue
Kim Calder
Elizabeth Abbott
Georgia Maheras
Barbara Rea
Mark Schoeberl
Bonnie Burns

Date: October 18, 2010

Re: Medical Loss Regulation

We are writing as consumer representatives to the NAIC, representing millions of American health insurance consumers. We would like to state again our appreciation to the NAIC for the opportunity we have had to be a part of the NAIC's remarkably open and participatory process that has led to the REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZED METHOLDOLOGIES FOR CALCULATION OF THE MEDICAL LOSS RATIO FOR PLAN YEARS 2011, 2012 AND 2013 PER SECTION 2718 (b) OF THE PUBLIC HEALTH SERVICE ACT approved by LHATF and the B Committee last week. We urge you again to adopt the rule as proposed by the Subgroup and not to make radical changes in the rule at this late date in the process without adequate consideration of the perspectives of all interested parties or time to fully address all issues raised by last-minute changes.

We believe that this rule reflects a serious attempt by the PPACA Actuarial Subgroup to accommodate the concerns of all interested parties and to devise a practical and workable solution to the issues presented by the MLR requirement that remains faithful to the wording of the statute. The B Committee, Executive, and Plenary are, of course, participants in this process, and you can raise issues not addressed in the earlier process or even reverse decisions earlier made. At this moment, however, a host of changes are being pressed by the insurance industry (or segments of the industry) that would uniformly weaken the MLR rule and make it less advantageous to consumers. They also all reduce the transparency and integrity of the rule. We believe that the balance of the current rule could easily be lost; indeed some of the current proposals would result in a rule that would not be in conformity with the statute and could not be certified by HHS. We urge you, therefore, to consider any changes with great care, and in particular to consider whether they are permissible under the statute and whether they are consistent with your role as protectors of health insurance consumers.

Specifically, we urge you to:

1) Retain the definition of "health insurance issuer" as a state licensed entity rather than permitting aggregation at the national level. "Health insurance issuer," the operative term in section 2718, is a term defined in section 2791 of the Public Health Services Act. The definitions of section 2791 are expressly adopted for Title I of the Affordable Care Act by section 1551. "Health insurance issuer" is a term that has been defined since HIPAA as an entity licensed at the state level and is used in 99 federal regulations. The NAIC simply has no discretion to redefine for the purposes of this one rule a term that has had a settled meaning in federal law for 14 years and that is used throughout the Public Health Services Act, ERISA, the Internal Revenue Code, and the Affordable Care Act. The legal opinion submitted yesterday by Miller Chevalier supports this understanding of the statute. Moreover, defining "health insurance issuer" in terms of a national holding company is inconsistent with the goal of state-based regulation which the NAIC fought for before Congress and which was ultimately adopted by the ACA. Different states will have different MLR thresholds and different definitions of large and small group. Allowing issuers to aggregate experience will result in regulatory complexities and inequities among states that are best avoided. Moreover, as the attached memorandum from AIS Risk Consulting demonstrates, aggregation would facilitate gaming by a handful of national companies to shift costs and profits among subsidiaries to the detriment of consumers and to the disadvantage of state and regional carriers. This change in the rule should be rejected.

2) Retain the current 50 percent confidence level rather than moving to an 80 percent confidence level. As demonstrated by the attached AIS memorandum, a 50 percent confidence level would not hurt insurers who are pricing at 80 (85) percent. On the other hand, an 80 percent confidence level would remove the incentive that the MLR provision creates for insurers who were pricing below 80 (85) percent to become more efficient. The current regulation was fully debated by the Subgroup and treats both insurers and consumers fairly. It simply says that if it is more likely than not that a carrier is pricing to below the 80/85 percent threshold, the consumer gets a rebate. If it is more likely than not that the carrier is pricing correctly, no rebate is paid. Moving to 80% seriously undermines the purpose of the rule and would remove the pressure that the rule puts on insurers to aim for the 80/85 percent threshold. The NAIC should stick with the current rule.

3) Not change the definition of contract reserves. Contract reserves should be reported for MLR purposes as they are in the annual statement. Any other approach would result in "two sets of books" and create a serious risk of gaming. LAHTF voted on Sunday to retain the current rule by a vote of 9 to 2, and this position should be upheld by the B committee, executive, and plenary.

4) Return to the treatment of rebates granted in an earlier year proposed by the PPACA Actuarial Subgroup for the year 2013 rather than the approach adopted by the B Committee. The approach adopted by the B Committee essentially guarantees that a carrier that underprices its premiums will never be driven to the 80/85% threshold by the

threat of rebates, as its rolling-average MLR including rebates from earlier years will always be higher than its actual MLR. Moreover, 2718 does not permit the treatment of rebates as "reimbursement for clinical services," as it would have to under 2718(b)(1)(B)(ii) if they were to be considered as part of the rolling-average MLR calculation, thus this change violates the statute. The Subgroup approach is the appropriate way to handle the treatment of prior reported MLRs, and we urge you to return to it. See again the attached memorandum from AIS Risk Consulting.

5) Resist any more last-minute attempts to revise the blank definitions approved unanimously in Seattle by the full plenary and incorporated into the rule. We attach the memorandum we submitted to B committee last week in opposition to these changes.

Finally, we understand that AHIP and Commissioners from certain states have suggested a nationwide phase-in of the MLRs between now and 2014. Whether or not this makes sense as a matter of policy (and it does not), this is simply not permitted by section 2718, which only gives HHS the authority to "adjust" the MLRs, and only on a state-by-state basis. Any proposals for handling the transition in a different way must be addressed to Congress, not to the NAIC.

For these reasons, we urge you again to adopt the rule as proposed by the PPACA Actuarial Subgroup and forward it to HHS for certification.

LEADING EDGE POLICY & STRATEGY

October 15, 2010

VIA EMAIL TRANSMISSION
c/o Kay Noonan, Jolie Matthew

Jane L. Cline
President
National Association of Insurance Commissioners

National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

Dear Commissioner Cline and and National Association of Insurance Commissioner members:

We appreciate the hard work of the National Association of Insurance Commissioners (NAIC) with respect to the medical loss ratio (MLR) rule described generally in new section 2718 of the Public Health Service Act. We write to ask the NAIC to address certain concerns with the proposal. Specifically, we want to remove any disincentives for programs that reduce uncoordinated care or unnecessary medical costs, regardless of any primary purpose test. Moreover, we would like NAIC and others to be cautious about the need for changes in payment and insurance approaches. We believe the current proposal may pose a straight-jacket that fails to contemplate other forms of payment policy that we will need as a country going forward. We believe there should be a further public discussion of impacts on health care costs and access to insurance with regard to this provision.

There are Hundreds of Billions of Dollars Wasted Annually Due to Unnecessary Medical Expenses

At a June 15th speech before the American Medical Association President Obama stated, in part:

> Make no mistake: the cost of our health care is a threat to our economy. It is an escalating burden on our families and businesses. It is a ticking time-bomb for the federal budget. And it is unsustainable for the United States of America….

These statements are backed up by the Congressional Budget Office, the Medicare Trustees and actuaries and HHS. As stated by the Congressional Budget Office, the federal budget is on an unsustainable path, primarily because of rapidly rising spending on health care.[1] CBO has also noted that many experts believe that a substantial share of spending on health care contributes little if anything to the overall health of the nation. Perhaps the most compelling evidence suggesting that opportunity is that per capita health care spending varies widely across the United States, and yet the very substantial variation in cost per beneficiary is not correlated with health outcomes overall.[2]

Peter Orszag, former director of the White House Office of Management and Budget, in a May 2009 interview with National Public Radio stated:

> "Estimates suggest that as much as $700 billion a year in healthcare costs do not improve health outcomes. They occur because we pay for more care rather than better care. We need to be moving towards a system in which doctors and hospitals have incentives to provide the care that makes you better, rather than the care that just results in more tests and more days in [the] hospital." —

Southeastern Consultants (SEC), one of the signators below, has performed and presented to the Institutes of Medicine a recent analysis of nine million Medicaid only and Medicaid/Medicare dually enrolled patients in five large states. [3]We found a group of patients and systems exhibiting patterns of extreme uncoordinated care. According to the study, potential average savings in the period of 2010-2018 from addressing these problems are estimated at $240 billion per year or an average of 8.8% of the total annual expenditures for direct care services. That would be over $2.4 trillion for a decade.

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[1] Elmendorf, Doug, *Congressional Budget Office*, Letter to Senator Kent Conrad, July 16, 2009. <http://www.cbo.gov/ftpdocs/103xx/doc10311/06-16-HealthReformAndFederalBudget.pdf>.

[2] Congressional Budget Office, Budget Options: Volume 1: Health Care, December 2008. <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>

[3] Mary Kay Owens, *Identifying and Quantifying the Costs of Uncoordinated Care: Findings from a Multi-State Analysis*, presented at the National Academy of Science, Institute of Medicine's workshop Series "The Health Care Imperative: Lowering Cost and Improving Outcomes", May 21, 2009. <http://www.iom.edu/~/media/Files/Activity%20Files/Quality/EBM/MKOwens.ashx>

Pricewaterhouse Coopers found an even greater amount. [4]Their research found that wasteful spending in the health system has been calculated at up to $1.2 trillion of the $2.2 trillion spent in the United States, more than half of all health spending. Defensive medicine, such as redundant, inappropriate or unnecessary tests and procedures, was identified as the biggest area of excess estimated at $210 billion annually.

A recent white paper by Thomson Reuters states that $75-$100 billion may be wasted in inefficiencies in the care delivery processes of individual provider including unnecessary one-day hospital admissions, overutilization of testing for hospitalized patients, and over-utilization of intensive care units. The paper describes a reasonable range for annual waste for unwarranted use of medical services at $250-$325 billion. The white paper further describes a reasonable range for annual waste from fraud and abuse to be $125-$175 billion.

Adoption of evidenced-based practices is lacking, as documented by the 2003 RAND Corporation study showing that only 55% of patients receive recommended care.

In a 2008 report, CBO outlined substantial geographic variation in health care spending that could not be attributed to differences in health status.[5] One of the recommendations of a Commonwealth Fund paper is to limit payments in high cost areas.[6]

The Medical Loss Ratio Rule as Currently Proposed by the National Association of Insurance Commissioners Undermine Efforts to Reduce Needless Medical Costs

Subsection 2718(a) of the Public Health Services Act as amended by Affordable Care Act (ACA), PL 111-148, directs the Department of Health and Human Services (HHS) to require that health

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[4] Pricewaterhouse Coopers, *"The Price of Excess: Identifying Waste in Healthcare Spending"*, April 2008. <http://www.pwc.com/us/en/healthcare/publications/the-price-of-excess.jhtml>

[5] Congressional Budget Office, Geographic Variation in Healthcare Spending, February 2008.

[6] C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending, The Commonwealth Fund, December 2007

insurance issuers annually report on the percentages of premiums spent on (1) reimbursement for clinical services, (2) activities that improve health care quality, and (3) all other non-claims costs, including an explanation of the nature of such costs, and excluding State taxes and licensing and regulatory fees. Further, subsection 2718(d) directs the Secretary in consultation with the National Association of Insurance Commissioners, to establish uniform definitions including for these categories. [Subsection 2718(b) creates requirement that, beginning not later than January 1, 2011, health insurance issuers offer an annual rebate to the extent the premium revenue devoted to the first two categories fail to exceed 85% percent of the total amount of premium revenue in the group market or 80% percent in the individual markets. The total amount of premium revenues for purposes of the MLR excludes Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance. States may by regulation lower these percentages subject to certain criteria.

The proposed MLR, as constructed, would appear to create disincentives toward addressing the hundreds of billions of dollars wasted in unnecessary or inappropriate medical costs. An insurer that takes efforts to reduce these costs is potentially penalized in several ways. First, the relative amount spent on medical costs would go down where there is an effective program to reduce inappropriate medical costs. Under the MLR, such a program makes it harder to meet the 85% or 80% thresholds. Accordingly, costs like salaries or profit would be further restricted --- hardly a formula to encourage companies or employees to find ways to eliminated this waste.

Second, costs associated with programs to reduce such costs may or may not be included in the 85% or 80% basket. It will be difficult to ascertain whether such programs meet the tests to be a “quality” program. NAIC has recommended a primary purpose test whereby if the primary purpose is to reduce costs, it would not qualify. For many reducing inappropriate or unnecessary care does increase quality. We have limited resources and limited access. Reducing unnecessary care should be viewed as a positive to allow greater appropriate care.

Third, the formulas, definitions, and ratios do not seem to accommodate a variety of payment policy options. We have struggled with fee-for-service payment systems as a potential cause of the volume of unnecessary or inappropriate medical costs. We are evaluating new models that may involve global payments or payments for managing certain populations. It is very unclear how the MLR construct would work with such new models.

Fourth, the proposal would seem to treat all categories of plans to the same test. For example high deductible plans carry less volume of medical costs, but also create different incentives for keeping costs down will taking on risks that should be borne by insurance. The MLR would seem to penalize such plans. In doing so, the MLR is simply taking away options that many Americans may want.

Finally, the MLR is a series of excessively refined definitions. Implementing the reporting and other evaluation systems need more bureaucracy and create more burdens for insurers, providers, and governments. Ultimately, this adds more to health care costs.

The simple mathematics and logic of the problem may be illustrated by the basic formula that the proposed MLR rule creates. As discussed above, whether they are called medical costs or quality initiatives, such expenditures may be either inappropriate or inefficient ones that would needlessly increase premiums. Let's call the appropriate medical costs and quality initiatives X and inappropriate medical costs or other wasteful quality programs Y. We want spending on X and not on Y. Similarly there are costs that NAIC does not call medical costs or quality initiatives. These additional costs may be costs that we think are good and appropriate and others that we think are not. Let's call the good costs A and the ones we think are inappropriate or excessive B. The MLR says (X+Y)/(X+Y+A+B) must be less than 85% or 80% as prescribed. This does nothing to incentivize reducing Y which is hundreds of billions of dollars annually in excess costs. In fact, the proposed rule creates a disincentive for reducing Y. The formula does create an incentive for keeping the amount spent on A+B low, but nothing says that any reductions will come out of B. It may very well be that items we want, such as fraud and abuse programs, program integrity provisions, general customer relations and other good features under A will take a hit. The MLR makes and artificial and arbitrary separation of preferred and not preferred with no reference to business innovation, different business models, competitive practices. Moreover, it is unclear whether costs on the "medical" side or "quality" side are not themselves based on inefficient bureaucracy or in appropriate care.

We should not to create barriers or disincentives for reducing wasteful, excess, or duplicative services or fraud and abuse. Programs that help reduce such waste should not pose a dilemma for those implementing such programs. We believe it needs to be clearly stated that efforts to reduce uncoordinated and unnecessary care and administrative costs associated with such efforts are within the 85% and 80% baskets.

Feel free to contact Nandan Kenkeremath, President, Leading Edge Policy and Strategy at 703-407-9407 if you have questions concerning these comments.

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