Illinois Department of Insurance

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Governor

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Director

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Via Facsimile and First Class Mail
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Re: ***Section 2718 of the Patient Protection and Affordable Care Act ("Act").***

Dear Steve and Lou:

Thank you for the energy, skill and time you have devoted to leading the state insurance regulatory effort to develop national standards for Section 2718 of the Act. Your national leadership in shaping the relevant definitions will have a significant and positive impact on the implementation of the Act and our Department is grateful for your leadership.

Context

This letter is intended to provide clarity on the State of Illinois' position on the subject of medical loss ratios. We recognize and respect that different states have different views on this and related topics.

At present, Illinois has an exclusively for-profit health insurance industry. Our Department lacks state-based legal authority to approve or deny proposed health insurance premium increases which, by Illinois law, are not required to be actuarially justified.

While the percentage of a base rate increase is filed with our Department for the individual market, small group carriers often submit a one-page letter attesting to compliance with Illinois' exceptionally broad rate bands. Illinois law does not require that a health insurer provide any information to our Department for large group rate increases.

Healthy Illinois families can be denied coverage for any reason other than "race, color, religion or national origin": one healthy mother with three healthy children was denied coverage because she attended a group grief counseling session after her husband died. According to a recent NAIC survey, health insurance for Illinois families is rescinded more than any other state in the U.S. – significantly more than California. One insurer attempted to rescind coverage of a teenager because her parents failed to disclose that she had a "congenital deformity" – she wore braces to straighten her teeth.

Base rates for women – independent of maternity benefits – can be 57% higher than the base rate for a man of the same age, geography and health status. For at least five (5) years, individual market premiums in Illinois have increased explosively. Small groups experience rate increases of 50% or more, and even high deductible plans are experiencing rate increases of more than 35%.

Position

Given the pervasive dysfunction of the Illinois health insurance marketplace, we offer the following parameters for your efforts:

1. **Definitions**: Section 2718(c) of the Act requires the NAIC to develop "uniform definitions" and "standardized methodologies for calculating measures of such activities." While we respect the variety of viewpoints, we urge narrow definitions that are strictly limited and contain hard, empirical boundaries. Our collective, fact-based understanding of "activities that improve health care quality" should not be constrained by industry opposition.

   For example, we oppose the blanket inclusion in the definition of certain "costs," like those associated with utilization review or fraud prevention, when those categories may be broadly – and inappropriately – expanded by insurers. To the extent that an exception or exemption from a narrow definition is appropriate, for innovation or otherwise, the state regulator can exercise that discretion upon request of the insurer after considering all relevant information.

   A detailed, explicit and limited definition of "activities that improve health care quality" should be accompanied by the opportunity for regulators to exercise state-based discretion if variance from the definition is needed. As you well know, insurance and health care markets differ from state to state and within a state – state regulators should have the opportunity to make decisions that integrate geographic, demographic and market nuance.

   In short, we urge definitions that are defined, narrow, and firm, but that establish a "baseline" or "floor" and allow state regulators to exercise discretion, if necessary, to serve the public interest.

2. **Frequency of Reporting**: Many health insurers are publicly traded and required to report financial status both to the Securities Exchange Commission and shareholders on at least a quarterly basis. As insurance regulators, we reasonably expect that health insurers maintain the loss ratio data elements and monitor financial conditions on a weekly if not daily basis. Accordingly, health insurers should be required to provide medical loss ratio data on a quarterly basis.

   America's Health Insurance Plans (AHIP), as well as other health insurance advocacy groups, argue that increasing insurance premiums reflect increasing underlying health care costs, an assertion all agree to be at least party true. Quarterly reporting of medical loss ratios by health insurers to insurance regulators will promote better understanding of: (1) the factors that drive our health care economy; (2) whether an insurer's quarterly or seasonal ratios reflect annual utilization patterns; and (3) whether certain benefit plans or arrangements are more likely to result in efficient, year-round care delivery.

Since providers have expressed concern about the capacity limitations of primary care physicians, quarterly loss ratio reporting may illuminate whether plan terms can or should be modified and staggered to manage physician utilization.

At a minimum, the NAIC work product should establish only a minimum expectation of reporting frequency which state regulators may elect to exceed. In other words, if the NAIC draft calls for annual reporting, then the lead state/regulator should have the discretion to request more frequent reporting.

Thank you for your attention to these important concerns. Please do not hesitate to contact me if you have questions or would like more explanation.

Very truly yours,

Michael T. McRaith
Director

MTM:srb