

October 13, 2010

The Honorable Kathleen Sebelius  
Secretary  
U.S. Department of Health and Human Services  
Washington, DC

Dear Madame Secretary:

The Patient Protection and Affordable Care Act (PPACA) establishes a minimum loss ratio and rebate program that begins January 1, 2011. As you know, the law requires the National Association of Insurance Commissioners (NAIC) to develop the uniform definitions and standard methodologies for calculating the medical loss ratio (MLR). The NAIC has used an open and transparent process to complete its work and we are pleased to report that we will soon be forwarding to you the results of that effort.

As state regulators conclude their work and HHS prepares to add the definitions and methodologies to the broader federal regulation, we write to highlight several issues that have come to light during our extensive deliberations on the MLR, and encourage HHS to address these in the final federal regulation.

## **I. Solvency and Competitive Markets**

As Commissioner Cline stated in her letter to you of June 1, 2010, the “medical loss ratio and rebate program in PPACA have the potential to destabilize the marketplace and significantly limit consumer choices.” While the reforms also may enhance the value of plans for consumers and improve carrier accountability for spending and pricing decisions, improper or overly strident application of the MLR and rebate program could threaten the solvency of insurers or significantly reduce competition in some insurance markets.

State regulators understand that the threshold consumer protection is ensuring a health insurance company is solvent. If the insurer is unable to pay claims after the patient receives care, additional consumer protections are unhelpful. If improperly applied, the new MLR requirements could impair the ability of insurers to maintain sufficient capital and comply with risk-based capital requirements. While the regulations developed by the NAIC do address this concern, we must remain vigilant so that the final regulations do not hinder the ability of state insurance regulators to preserve financially stable markets.

## **II. Phase-In of Medical Loss Ratio Limits**

While some states seek national relief from the 2011 MLR, all states recognize that transitional relief may be appropriate for some state insurance markets. State regulators intend to provide HHS with fact-based recommendations on which transitional state or insurance market exemptions should be based.

During the Congressional debate on PPACA, the NAIC expressed concern about the ability of many insurers in the individual market to comply with an 80 percent MLR prior to 2014. In the NAIC’s letter to Majority Leader Reid and Speaker Pelosi on January 6, 2010, we wrote:

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We are concerned that a loss ratio of 80% in the individual market may not be readily achievable by many insurers. These companies have already entered into contracts with agents and brokers that obligate them to pay specified levels of commissions, and have expenses associated with underwriting and marketing that they will not be able to reduce until guaranteed issue requirements and health insurance exchanges are implemented.

While carriers will be required, by the MLR, to limit administrative expenses beginning in 2011, the Exchanges, rating and market reforms, and other key PPACA provisions designed to reduce administrative costs will not go into effect until 2014.

Health insurance companies in some markets will need a transitional period to comply with the 80 percent MLR limit. In the absence of the transitional period, the markets of some states are likely to be “destabilized.” Section 2718(b) of PPACA states that “the Secretary may adjust [the MLR] percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.”

As consumer representatives noted during NAIC deliberations, consumers will not benefit if companies are forced out of the market and individuals are left without coverage. State regulators are most familiar with local health care and health insurance markets. Accordingly, we hereby advise you that the following factors will be considered by regulators, supported by the NAIC and its database, when determining whether application of the MLR would “destabilize” the individual market:

- The potential impact on insurer solvency;
- The potential loss of carriers marketing products in the state and the impact on consumers and competition in the marketplace;
- The ability of consumers to find easily affordable products in the state should their carrier leave the state market;
- The potential impact on benefits and cost-sharing of existing products;
- The potential impact on premiums paid by current policyholders; and
- The potential impact on consumer access to agents and brokers.

State regulators will objectively evaluate these criteria when determining whether to seek transitional exemption from the MLR and rebate program. In addition, when recommending to HHS that a transitional exemption should be applied to a state or insurance market, the regulator shall also propose a solution to the factors on which the recommendation is based. We urge HHS to give deference to the analysis and recommendations of state regulators when determining how the new requirements will be phased-in.

In addition, as important consumer protections and assistance programs are implemented over the next four years, and as insurance markets evolve during the transition to Exchanges, the role of insurance producers (agents and brokers) will be especially important. We encourage HHS to recognize the essential role served by producers and accommodate producer compensation arrangements in any MLR regulation promulgated.

Obviously, time is critical. Carriers need to know well before January 1, 2011, what will be required of them so they can appropriately set rates, adjust business practices or reassess their position in various markets. The commissioners in Maine, Iowa and South Carolina have already requested your assistance. We urge continued collaboration between HHS and state regulators to ensure the MLR and rebate program do not have unintended consequences.

### **III. Application of the Medical Loss Ratio to Expatriate Policies**

The NAIC's PPACA Actuarial Subgroup and Health Reform Solvency Impact Subgroup received many letters and comments from insurance companies that sell expatriate and international policies recommending that these plans be exempt from the medical loss ratio limit because the nature of the benefits provided under these plans makes it all but impossible for them to comply with the 80 percent limit. While they made a compelling argument, and we agree that they should be exempt from the medical loss ratio requirement, we concluded that this determination is ultimately the responsibility of HHS to make.

Expatriate and international policies provide health insurance coverage in a variety of unique circumstances. Some policies are group health insurance policies sold to employers for a unique subset of their employees and their families including primarily expatriates (employees working outside their country of citizenship), third country nationals (employees working outside of their country of citizenship and outside the employer's country of domicile) and key local nationals (citizens working in their home country). By definition, expatriate and international policies cover individuals who travel frequently and who may return to their home countries for both business and personal purposes. Expatriate and international policies offer global coverage and, therefore, generally provide health coverage to individuals while in their home country as well. For example, a policy covering a missionary from the U.S. working in Africa would need to provide coverage for that missionary when he returns to the U.S. for two weeks over the holidays.

These policies typically provide unique benefits that are: 1) designed with additional high-cost features required to meet the unique needs of individuals living, working, studying and traveling abroad; 2) tailored to each destination country; and 3) packaged with support services, such as coverage of medical evacuation and translation services, that are not found in domestic health plans. Additionally, unlike insurers that operate in the U.S. where doctors and hospitals are highly regulated, international insurers play a significant role in assisting their members in finding qualified English-speaking doctors and high quality hospitals, especially in parts of the developing world where hospitals and doctors are largely unregulated. All of these additional services would be classified as "administrative" under the medical loss ratio, but are critical to the delivery of care

Expatriate and international policies contain inherently higher administrative costs attributable to the additional complexities of administering international coverage (e.g., the costs of developing/maintaining provider networks in multiple countries, paying claims cross-border and in multiple countries, mitigating exposure to fraud, manually processing claims in multiple currencies and languages, operating multi-lingual 24/7/365 call centers in multiple times zones, etc.). In addition, the average premium for these types of policies is generally lower than domestic health insurance coverage. Thus, direct application of medical loss ratio limits to this unique market may have a disruptive effect. An unintended consequence of direct application of the MLR requirements to this unique market may be to disadvantage U.S. insurers relative to foreign competitors that are not subject to the same requirements. Finally, there may be additional complexities implementing rebates due to the transient nature of international travelers, students and expatriates. The high cost of transferring funds internationally may make it burdensome and costly for these types of plans to administer and comply with the rebate provisions.

For these reasons, we recommend that expatriate and international plans be exempt from the medical loss ratio limit and rebate. In the event such an exemption is not possible, we recommend that adjustments be made to their medical loss ratio percentage, additional quality improvement activities be identified for these policies, and they be pooled differently to take into consideration their special situation.

We also note that the NAIC continues to look at the impact of the MLR on other "different" plans, such as high-deductible plans, to determine whether any modifications to the methodology for calculating the MLR are justified. Our findings will be forthcoming.

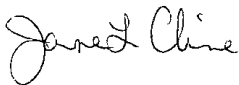
#### IV. Payment of Rebates

The NAIC determined that our responsibilities under the law did not include outlining the details of the rebate program. However, issues surrounding rebates have been discussed by regulators and interested parties during our many conference calls. Based on those conversations, we provide the following recommendations:

- Rebate payments should be made to the individuals or entities that paid the premiums. If the employer pays the premiums on behalf of the employees, then the rebate check should be sent to the employer for distribution to the enrollees. If the individual pays the premiums directly, then the rebate check should be sent directly to the individual. We also recommend that the Department of Labor provide guidance on the distribution of the rebate payments by employers to ensure the individual employees receive their fair share of rebate.
- Policyholders eligible for payment of a rebate should have the rebate paid in the form of either a premium credit against future premiums due or a check to the policyholder.
- The carriers should be required to make a good faith effort to locate the owner of the rebate check, for example, a phone call, e-mail, communication with the agent or broker, and an online search. Such good faith efforts would be subject to routine market conduct reviews by state insurance departments. If all attempts are unsuccessful, the returned rebate should be handled under abandoned state property laws.

In conclusion, and in response to your letter of September 14, 2010, let us assure you that the NAIC continues to work diligently to complete the tasks charged to us by the law. Our goal is to produce uniform definitions and standard methodologies for calculating the medical loss ratio that will protect consumers and preserve competitive markets and solvent carriers. Through our open, deliberative process we hope to deliver to you a final product that achieves this goal in October and we look forward to working with you on these issues, as well as many other implementation issues, in the months to come.

Best regards,



Jane Cline  
West Virginia Insurance Commissioner  
NAIC President



Susan Voss  
Iowa Insurance Commissioner  
NAIC President-Elect



Kevin McCarty  
Florida Insurance Commissioner  
NAIC Vice-President



Kim Holland  
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