



# UTAH ASSOCIATION OF HEALTH UNDERWRITERS NEWS

JANUARY 2011



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# PRESIDENT'S MESSAGE

## WELCOME TO 2011!

By Ernie Sweat CEBS, UAHU Past President

What a difference a year makes. This time in 2010 it appeared that Barack Obama's version of a Health Care Reform bill was no more than a gleam in his eye. The House version would never pass the Senate, and a more moderate Senate version would alienate the Democratic Progressive base. Of course that was before we learned about Cornhusker Kickbacks, Louisiana purchases and the like. It was also before we realized how Reconciliation can be used for items that really have little to do with the budget and much more to do with domestic policy. Just think of how politically naïve we were as we rolled from the "alts" to the "teens" and how dead wrong our Civics teachers were on the necessity for compromise across the aisle to get sweeping bills passed. The PPACA, ACA, Obamacare, whatever terminology you care to use; will be remembered for many years as both a testament to the ability for Washington to get things done when the determination is strong, and a showing of the worst side of politics to an already jaundiced American public.

So now that we are almost 6 months into the actual implementation of this bill, let's account for what we have. The new law was supposed to provide additional protection for children under the age of 19. No longer can an insurance carrier decline a policy to a potential member in this age bracket. Of course the good people who devised this plan never considered the cost of risk to the insurer. If you must take all, then the other alternative is to take none; thus the demise of the "Kids Care" policies for children only. For many families, these policies were the difference between affordable and unaffordable health insurance. What exactly does ACA stand for?

We also have new mandated benefits for grandfathered plans and even more mandates for those who are unable to get this label attached to their plan. There is no question that the coverage is stronger (no lifetime or annual limits, a slough of new preventive services paid at 100%, emergency room coverage paid the same at every facility...just for

starters), but all that comes at a price. Nationally the statistics vary by carrier which is not surprising considering that no two contracts are identical. That being said, a small business owner can expect to pay somewhere in the range of an additional 4-6% on their upcoming health insurance renewal just to account for the mandated benefits. Of course our economy is not exactly humming along. Our small business owner clients needs higher health insurance rates about as much as they need the recession to deepen. Yet, this is exactly what we are giving them. Tell me again what ACA stands for?

The magic bullet in the Secretary of HHS's revolver to offset all these increased costs is to implement a forced minimum loss ratio on insurance carriers. No longer can they skim 20, 30, 40% off the top to put in their pockets and pay for their lavish trips to the Bahamas. The only problem with this is that most of the carriers in the country already operate on fairly skinny margins; more like 4-8% if they are lucky. The big secret held from the American People was that the vast majority of premium collected by insurance companies went right back out the door to pay claims. Adhering to the loss ratio minimums adds very little additional money to the combat of medical inflation...which is still rampant. Inflation by the way won't be hindered whatsoever by the new mandated benefits. In fact, the infrastructure is being built to take this to an even higher level. So tell me once again what ACA stands for?

2011 should be a very interesting year indeed. By the dawn of 2012 every company in the nation with a group health plan will have had to adhere to the new rules. 2012 will also be an even more enjoyable year in that we will begin to truly see the full effect of what the new taxes will do our premiums. Stay tuned on that one. ACA...are you kidding me?



# Medical Loss Ratio Provisions

Another HUGE topic of interest right now is the medical loss ratio provision included in the PPACA. NAHU members are not alone in their concern about how the MLR requirements and rebate provision will be implemented. We have joined with the Independent Insurance Agents of America (IIAA) and the National Association of Insurance and Financial Advisors (NAIFA) to form the Agent/Broker Alliance.

Reprinted here is an October 4, 2010 letter the Agent/Broker Alliance sent to the Chair of the Accident and Health Working Group—PPACA Subgroup. This is just one more example of the value of your NAHU membership is providing to you during this turbulent time in our industry.

Dear Mr. Ostlund:

The Agent/Broker Alliance, which collectively represents more than 500,000 state-licensed health insurance producers, is pleased to offer comments on your Working Group's draft regulation for Uniform Definitions and Standardized Rebate Calculation Methodology for Plan Years 2011, 2012 and 2013 as per Section 2718(b) of the Public Health Service Act.

As agents and brokers, our members work on a daily basis to help individuals and employers purchase health insurance coverage and service the health insurance policies of millions of Americans. As such, it is of paramount importance to us that state health insurance markets remain competitive and that we have a wide range of affordable health insurance products to offer to our clients. The Agent/Broker Alliance is concerned that the current draft regulation does not adequately provide for a transition period for states regarding the medical loss ratio (MLR) requirements, and that this lack of a transition will be extremely destabilizing for the individual and small group markets in many states.

The Patient Protection and Affordable Care Act (PPACA) requires that the MLR requirements apply to the 2011 calendar year and gives the NAIC the authority to develop the corresponding rebate calculations and methodologies. Even though the

MLR rules and parameters are not fully developed, rates for January 1, 2011 renewals are being set now and our members are presenting plan options and rates to their clients today. These rates cannot possibly be reflective of requirements that are not yet known. We know that individual states have the ability to request transition relief and a waiver from requirements pertaining to their individual markets from the federal Department of Health and Human Services (DHHS) if they believe the MLR requirements will be too destabilizing. However, we also believe that the NAIC has the ability, through the establishment of these rebate calculations, to provide uniform and needed transition relief to all of the states for both the individual and small group markets, and would like to see this draft amended accordingly. The rebate transition process should be staged over the next three years, and PPACA requirements across the board are fully implemented to minimize market disruption and preserve consumer choice of affordable coverage.

Since companies have had to set 2011 plan year rates before all of the new MLR requirements are known, we believe that the NAIC regulation should require the issuance of rebates based on existing state MLR requirements. Those states that follow the NAIC rate filing guidelines for individual coverage would utilize the loss ratio standard in the model, as would states that currently have no requirement. States that have higher standards would apply their existing requirements.

For the small group market, in states where there is no minimum loss ratio standard, the state's 2011 loss ratio requirements for the individual market could be used. In cases where there is no individual market requirement, we believe a starting point for transition would be 65 percent.

Once the 2011 baseline calculation is established, states could work off of that calculation for 2012 and 2013. Given that all states

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# Requirement that Carriers Justify Double-Digit Rate Increases A Teachable Moment?

BY ALAN KATZ

**R**easonableness, like a host of other things, can be in the eye of the beholder. Regulating reasonableness, consequently, is nothing like a science. Yet the Patient Protection and Affordable Care Act requires health insurance carriers to disclose their reasons for “unreasonable premium increases.” The Department of Health and Human Services has issued a preliminary version of the regulation aimed at determining how and where this rate increase disclosure will take place.

Lapse rates are highest during the first year a policy is in-force. This The draft regulation, which is open to comment and subject to change, requires carriers to publicly disclose any individual or small group rate increases higher than 10 percent. While double-digit increases will not be automatically considered unreasonable, they will trigger a review by state or federal regulators to determine if they’re justified. States will get the first shot at scrutinizing the rate hikes. Only if HHS determines a state lacks the ability to do a thorough actuarial review of premium increases will federal regulators step in. States are eligible for federal grants to bolster their review capabilities and 45 states have taken advantage of the program to date.

Over time this 10 percent threshold could be adjusted on a state-by-state basis according to the National Underwriter. “After 2011, a state-specific threshold would be set for the disclosure of rate increases, using data that reflect each state’s cost trends.”

HHS has the authority to require disclosure of large group rate increases, but chose not to do so. They’re asking for comments on the advisability of seeking disclosure of large group claims, but according to the National Underwriter, regulators are concerned that doing so would not align with current practices. 43 states, however, already review — and some can deny — rate increases on individual and small group medical insurance coverage. Significantly, neither the regulation nor the PPACA gives HHS the power to deny rate increases. If they determine a premium hike sought by a carrier is unjustified it will post that finding on a government website, but the increase will still be permitted (again, unless a state regulator prevents it).

## Extraordinary Service for Extraordinary Members.

The mechanics of the rate review are described in the proposed regulation. To oversimplify, if its desired rate increase is over 10 percent or greater, the carrier will need to notify HHS and post its justification on the insurer's web site. In evaluating the increase HHS will consider whether:

1. "the rate increase results in a projected future loss ratio below the Federal medical loss ratio (MLR) standard
2. "one or more of the assumptions on which the rate increase is based are not supported by substantial evidence.
3. the choice of assumptions or combination of assumptions on which the rate increase is based is unreasonable."

The timing of the rate increase is determined by state law, so HHS' review cannot delay implementation of the rate change. What it will do, however, is require disclosure of a great deal of information, bringing an unprecedented amount of transparency to the rate setting process.

Transparency is one of the reasons Consumers Union praises the draft regulation. According to Kansas City InfoZine, its spokesperson, DeAnn Friedholm, cited two benefits the group expects the premium regulations to deliver: "First, it provides a strong incentive for insurers to do a thorough review of their justifications before asking for big rate increases. And second, it

will help consumers better understand why their rates are going up and they can decide to look for better plans."

Which could lead to an interesting result. As the Consumer Union notes, the regulation could "help consumers better understand why their rates are going up ...." And the scrutiny on carriers explanation for increases will be intense. Which makes the posting of the reasons behind the price hikes a powerful "teachable moment."

Carriers can use the disclosure to tell a detailed explanation for their actions. For example, in California, hospital rates increased by 150% between 2000 and 2009. Carriers can, and should, get creative in presenting how this medical trend drives premium increases. The question is whether carriers, their actuaries and their attorneys have the skill and willingness to take advantage of this opportunity to present the full story behind skyrocketing insurance costs. Regence Blue Cross Blue Shield provides an example of a meaningful explanation for premium hikes. They even explain the impact of deductible leverage, which is no mean feat.

Regence is providing a general explanation of how pricing works, something other carriers will need to do as well. However, when justifying specific rate increases, Regence and others should go further, naming names. A hospital increases their reimbursement rates by 10%? Name the hospital. A pharmaceutical manufacturer

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## Extraordinary Service for Extraordinary Members.

introduces a new drug that costs 20% more than the effective medicine it replaces? Name the drug and the manufacturer.

Carriers could – and should – get even more specific. If the hospital initially sought a 20% increase the insurer should note its success in reducing the increase. After all, the beneficiaries of carriers' successful negotiations with providers are consumers. As I've noted previously, health insurers need to do a better job justifying their role in the system. Most health insurance executives would justify their enterprise's contribution to the system as lowering the cost of health care. Yet with every rate

increase they undermine this argument by offering the broad excuse that premiums are rising due to increases in "medical inflation." Well, now they have the forum and the reason to be specific about what — and who — is driving that inflation.

Who knows, some day regulators may decide to ask medical providers if their charges are reasonable. Until then, there's no reason carriers can't ask that question – publicly and loudly. As long as transparency is coming to rate setting, the bright light of disclosure may as well shine on as many parts of the system as possible.



*Alan Katz is the principal of the Alan Katz Group. Founded in 2007, the Alan Katz Group LLC offers clients consulting, public speaking and research services with an emphasis on health insurance, sales strategies and public policy. Alan Katz has deep experience in sales and in the health insurance industry. He has been an independent agent, led one of the nation's largest employee benefits general agencies, and served as a Senior Vice President of WellPoint, the nation's largest commercial managed care company. At WellPoint, Alan led the individual and small group sales organization and championed their online distribution strategy. His work on managing sales channel conflict was cited by Sales and Marketing magazine when, in 2000, it named WellPoint one of America's Top 25 Sales Teams. He is a past president of both the National and the California Association of Health Underwriters (Health Underwriters is the leading trade associations for health insurance agents and other professionals). In 2003 Alan received the Harold R. Gordon Memorial Award as NAHU's Health Insurance Person of the Year. He was named CAHU Member of the Year in 2000 and, for an unprecedented second time, in 2007. This article was most recently posted on Alan Katz's blog [www.AlanKatzWordPress.com](http://www.AlanKatzWordPress.com) and has been reprinted with permission.*

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# Grassroot Activism.

## Sowing Seeds of Change.

BY SUSAN MORGAN

If you ask people what they think about politics, the usual answer is a negative one. They think politicians are corrupt and dishonest. Some politicians certainly are corrupt, it's true, but only because people who are in politics for the wrong reasons are sometimes the only ones to make themselves available for that kind of community service. When the people who could do the most good in a community decide against trying to make things better because they don't want to associate with politicians, and don't want to be labeled as politicians themselves, they are leaving politics to those who are either dishonest or incompetent. Everyone loses.

A useful analogy is to think of politics the same way you think about a dirty house. If it needs to be cleaned, you divide up the chores and get the work done. Politics is just the same. If you work regularly with others to maintain our democratic political system, it's easier than it would be if you let things pile up and leave all the work to others. Neglect necessary work too long, and you'll end up with a real mess that requires a huge effort to turn around.

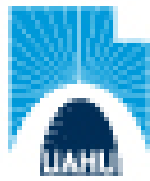
As conservatives, we should focus on grassroots politics because that's where some of the best opportunities for making changes can be found. Grassroots politics can alter the political landscape at every level of government, from the city, county, and state to the federal

government. Grassroots efforts make a difference because they affect local lives. And ultimately, the grassroots level is the one with the votes.

Let's elaborate a little on some of the reasons why grassroots organizations are a great way for you, personally, to get involved:

1. You'll get better results. Since so few people are active participants when it comes to politics, the ones who do get involved also have more influence than they would otherwise. (Liberal politicians have understood this principal for years and made good use of it.) Politicians often give their full attention to the people or groups that are likely to affect them and their campaign the most.
2. Grassroots organizations make it easier to keep conservative voters better informed. People in today's world have to deal with information overload all the time. Having access to an organization that can give you and other voters just the useful information you need to take action is a real advantage. Also, people are more likely to vote if they are informed and if they believe their votes will make a difference.
3. Grassroots organizations are a place to gain experience. If you get involved now on a grassroots level, your work there may allow you to get the political experience you need for more involved effort, at higher levels, later on. Many people who have made significant political contributions first got involved, and noticed, on a grassroots level.

A good grassroots organization is a good place for you to get involved with the politics that most directly affect your life. By participating in events like Day on the Hill, you may become one of the people in your community who chooses to make a significant difference in your community!



UTAH ASSOCIATION  
OF  
HEALTH UNDERWRITERS

# Day on the Hill & Third Annual “Dine with your Legislator”

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“This—the UAHU dinner—has become the premier event of the legislative session.”

Comment from a legislator following last year’s dinner.

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**Tuesday, January 25, 2011 3:00-5:30 p.m.**

**Why you should be there:**

A sit-down dinner with their Representatives and Senators on the night of the Governor’s State of the State Address gives our members a unique chance to visit and establish crucial personal relationships with their lawmakers.

UAHU legislative co-chairs Scott Deru and Alan Seegrist work hard on behalf of Utah’s brokers: serving on committees, attending meetings, studying issues, and meeting with legislators. Lobbyist Mike Sonntag’s many years at the capitol have earned him the respect and trust of our elected officials.

Join us to get the latest information from Scott, Alan and Mike regarding health insurance reform issues on the legislative agenda.

**Cost: UAHU members \$50 Non-UAHU \$80  
registration opens 12/3/2010  
<http://www.dayonthehill.regtx.com>**

We encourage you to personally invite your legislators; hearing directly from you is very important to them. Don’t know who they are? Click here to go to the Senate Website Map page to search for your Senator and Representative. <http://www.utahsenate.org/map.shtml>

Please note that this is not a revenue making event for UAHU; our costs exceed our income. Your registration helps buy a legislator’s meal. In addition we also invite legislators to bring a spouse/guest. However, we firmly believe that the goodwill that is generated during this event is well-worth the expenditure. Additional donations to cover legislators’ and guests’ meal costs are welcome.

## Schedule For Tuesday, January 25, 2011:

- 2:30 pm check-in (State Office Building Auditorium)
- 3:00-4:15 pm: Legislative briefing by UAHU Legislative committee
- 4:30-5:30 pm Dinner w/legislators in Capitol Rotunda
- 6:30 pm (non-UAHU event) Governor’s State of the State Address in House Chamber (Members are welcome to stay. Event open to the public but seating in gallery is limited)



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# UTAH ASSOCIATION OF HEALTH UNDERWRITERS

## 2011 LUNCHEON/EDUCATION SCHEDULE

### January 2011

- 12 Salt Lake Chapter Wednesday, luncheon**  
Brad Cooper — Corporate Wellness and The impact of Reform on Wellness Programs  
Intermountain Medical Center Campus, Doty Education Center
- 18 Central Utah AHU Chapter**  
3rd Tuesday of each month from 11:30 to 1:00 PM at Timpanogos Regional Hospital (750 W 800 N, Orem) in the Women's Center.  
**Charge is \$15.00.**  
Day On the Hill
- 25** 2:30 pm check-in (State Office Building Auditorium)  
3:00-4:15 pm: Legislative briefing by UAHU Legislative committee  
4:30-5:30 pm Dinner w/ legislators in Capitol Rotunda  
6:30 pm (non-UAHU event) Governor's State of the State Address in House Chamber (Members are welcome to stay. Event open to the public but seating in gallery is limited)  
**Cost: UAHU members \$50 Non-UAHU \$80 registration opens 12/3/2010**  
<http://www.dayonthehill.regtx.com>

### April 2011

- 13 Salt Lake Chapter Wednesday, luncheon**  
— TBD
- 19 Central Utah AHU Chapter**  
3rd Tuesday of each month from 11:30 to 1:00 PM at Timpanogos Regional Hospital (750 W 800 N, Orem) in the Women's Center.  
**Charge is \$15.00.**

### May 2011

- 18-19 Sales Symposium**

### February 2011

- 15 Central Utah AHU Chapter**  
3rd Tuesday of each month from 11:30 to 1:00 PM at Timpanogos Regional Hospital (750 W 800 N, Orem) in the Women's Center.  
**Charge is \$15.00.**

### March 2011

- 15 Central Utah AHU Chapter**  
3rd Tuesday of each month from 11:30 to 1:00 PM at Timpanogos Regional Hospital (750 W 800 N, Orem) in the Women's Center.  
**Charge is \$15.00.**
- 23 Salt Lake Chapter Wednesday, luncheon**  
Mike Sontagg— Legislative Update  
Intermountain Medical Center Campus, Doty Education Center
- 30 Salt Lake Chapter Ethics Seminar**  
**Wednesday, 9:00 am – 1:00 pm**  
Intermountain Medical Center Campus, Doty Education Center

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“This time, like all times, is a very good one, if we know what to do with it.”

Ralph Waldo Emerson

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# FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART IV



U.S. Department of Labor  
Employee Benefits Security Administration  
October 29, 2010

Set out below are three Frequently Asked Questions (FAQs) regarding implementation of the market reform provisions of the Affordable Care Act. They have been prepared jointly by the Departments of Health and Human Services, Labor and the Treasury (the Departments). Like the FAQs the Departments issued on September 20, 2010, October 8, 2010, and October 12, 2010, these FAQs answer questions from stakeholders with a view to helping people understand the new law and benefit from it, as intended.

The Departments anticipate issuing further responses to questions and other guidance under the Affordable Care Act in the future. We hope these publications will be helpful by providing additional clarity and assistance.

**Q1: The Departments' interim final grandfather regulations provide that, to maintain status as a grandfathered health plan, a group health plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan. Must a grandfathered health plan provide the disclosure statement every time it sends out a communication, such as an EOB (explanation of benefits), to a participant or beneficiary? If not, how does a grandfathered health plan comply with this disclosure requirement?**

**A:** A grandfathered health plan will comply with this disclosure requirement if it includes the model disclosure language provided in the Departments' interim final grandfather regulations (or a similar statement) whenever a summary of the benefits under the plan is provided to participants and beneficiaries. For example, many plans distribute summary plan descriptions upon initial eligibility to receive benefits under the plan or coverage, during an open enrollment period, or upon other opportunities to enroll in, renew, or change coverage. While it is not necessary to include the disclosure statement with each plan or issuer communication to participants and beneficiaries (such as an EOB), the Departments encourage plan sponsors and issuers to identify other communications in which disclosure of grandfather status would be appropriate and consistent with the goal of providing participants and beneficiaries information necessary to understand and make informed choices regarding health coverage.

**Q2: If an individual health insurance policy that was in place on March 23, 2010 included a feature that allowed a policy holder to elect an option under which he or she would pay a reduced premium in exchange for higher cost sharing, could such an election be made after March 23 without affecting the policy's grandfather status even if the increase in cost sharing for the individual would exceed the limits under the grandfather rule on increases in cost sharing?**

- A: Yes. The cost-sharing level that would apply under this option would be grandfathered as part of the policy in place on March 23, 2010 even if it did not apply for the particular individual at that time. As long as the policy holder had that option available on March 23 under the policy, he or she could exercise the option after March 23 without affecting grandfather status, even if the result would be that the particular individual's cost-sharing would increase as a result of electing this option by an amount in excess of the grandfather rule limits.
- Q3: An employer has maintained a plan since before enactment of the Affordable Care Act that reimburses expenses for special treatment and therapy of eligible employees' children with physical, mental, or developmental disabilities. The treatment or therapy is not covered by the employer's primary medical plan or plans. Reimbursable expenses may include expenses for special treatment or therapy from licensed clinics or practitioners, day or residential special care facilities, special education facilities for learning-disabled children, or camps offering medically oriented programs that are part of a child's continued treatment, or for special devices. The plan is operated separately from the employer's primary medical plans; employees who are otherwise eligible may participate in the plan without participating in those primary medical plans. The plan limits the total benefits for any eligible child to a specified lifetime dollar limit. Would it be a reasonable good faith interpretation of the Affordable Care Act and the regulations thereunder for the plan sponsor to take the position that the plan does not violate the prohibition, under section 2711 of the Public Health Service Act (PHS Act) and the related interim final regulations, on imposing a lifetime dollar limit on "essential health benefits," as defined in section 1302(b) of the Affordable Care Act (the lifetime limit prohibition)?
- A: Yes. In accordance with the preamble to the Departments' interim final regulations implementing PHS Act section 2711, for plan years beginning before the issuance of final regulations defining "essential health benefits," for purposes of enforcement, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits." (Of course, the regulations may differ in their definition of "essential health benefits" from reasonable interpretations used before the regulations are issued.) Accordingly, in the case of plans described above, for such plan years: (i) the Departments will treat as a reasonable good faith interpretation of section 2711 of the PHS Act and the regulations thereunder the position that the imposition of the per-child lifetime dollar limit on benefits provided under such plans does not violate the lifetime limit prohibition, and (ii) the imposition by such plans of such a limit will not result in an enforcement action by the Departments against such plans under PHS Act section 2711



UTAH ASSOCIATION OF HEALTH UNDERWRITERS

the Utah Association of Health Underwriters Political Action Committee (HUPAC) Monthly Contribution Form



“Every man owes a part of his time and money to the business or industry in which he is engaged. No man has a moral right to withhold his support from an organization that is striving to improve conditions within his sphere” – Theodore Roosevelt



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BUSINESS CITY	BUSINESS STATE	BUSINESS ZIP		<input type="radio"/> Check (made payable to NAHU) <input type="radio"/> Visa - see below <input type="radio"/> Master Card - see below <input type="radio"/> Pre-Authorized Checking - see below	
BUSINESS TELEPHONE		BUSINESS FAX			
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HOME CITY	HOME STATE	HOME ZIP		MAIL PAYMENT & APPLICATION:	
EMAIL ADDRESS			<b>Colleen Mellor</b> <b>VP MEMBERSHIP</b> <b>111 E. Broadway Ste 1400</b> <b>Salt Lake City, UT 84111</b> <b>Fax: 801-596-2650</b> <b>Phone: 801-533-8444</b>		
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■ **Medical Loss Ratio Provisions** - continued from page 5

have a different set of “starting points” (the 2011 loss ratio), an appropriate transition calculation would be to use 1/3rd of the PPACA loss ratio and 2/3rds of the state’s loss ratio for 2012 with the proportions reversed in 2013. Changes would be rounded to the nearest 5% since most loss ratio standards are currently rounded at this level. This will minimize disruption to consumers, and provide for a normalized path to 2014. At that time, since other PPACA market reforms will be phased in, the statute’s 80 percent loss ratio standard for the individual and small group markets could be applied evenly across all states for the purpose of issuing rebates to consumers.

In addition to urging an adequate transition for the issuance of MLR rebates, we would also like to comment on the draft’s exhibit C, Excerpts from the Supplemental Health Care Exhibit Instructions. The draft only included a portion of the instructions to be included with the Supplemental Health Care Exhibit and it did not include instructions for line 10, general and administrative expenses. When crafting those instructions, we recommend a note that the amount listed on line 10.2, agent and broker commissions, be excluded from the final total of general and administrative expenses used in the medical loss ratio calculation, since 100 percent of these fees are transferred to independent third-parties.

In the small business and individual market, health plans include commissions in their premiums, but pass 100 percent of these funds along to independent agents and brokers. This practice is a health plan consumer convenience, eliminating the need for businesses and consumers to prepare mail and track

separate payments to their benefit specialists. We recommend that your instructions include the direction to remove fully-disclosed pass-through fees collected by carriers and represented in line 10.2 from the MLR calculation since 100% of these fees are passed along to the licensed health insurance producer as a service to the health insurance purchaser. We also fully support disclosure of these fees to businesses and consumers. Such disclosures are common in the large group market segment-expanding this practice to the individual and small group markets would be a straight-forward process.

Exempting pass-through fees from the MLR calculation would preserve existing cost-saving practices in current health insurance markets and further the intent of the PPACA MLR provisions to reduce overall spending on administrative costs. At the same time, it would preserve an important operational convenience for small businesses and individuals.

We sincerely appreciate this opportunity to provide comments on the proposed regulation and appreciate the Working Group’s months of work on this critical issue. We look forward to working with you as consideration of the draft moves through the NAIC committee process. If we can be of further assistance, please feel free to contact any of our respective organizations.

Sincerely,

The Independent Insurance Agents of America  
The National Association of Health Underwriters  
*The National Association of Insurance and Financial Advisors*



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