MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON
OFFICE OF
INSURANCE COMMISSIONER

P.O. BOX 40255
OLYMPIA, WA 98504-0255
Phone: (360) 725-7000

October 11, 2010

Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
Via e-mail

To whom it may concern:

I would appreciate the U.S. Department of Health and Human Service's guidance on the following issues:

The Washington State Office of the Insurance Commissioner (OIC) recently communicated to its regulated carriers the effects that we believe the Patient Protection and Affordable Care Act (PPACA) will have on their association health plan (AHP) business[1] with respect to grandfathering, financial reporting, and the application of medical loss ratios. It is my understanding – based on our reading of PPACA and our work with HHS[2] and the National Association of Insurance Commissioners (NAIC) – that the Affordable Care Act does not recognize the association structure but rather applies directly to the individual plan, the small group plan, or the large group plan.

Grandfathering

Based on our current understanding of the law, grandfathering is governed by the status of the employer or individual's plan rather than by the "master contract" between the association and the carrier. For example, if an employer joined an AHP, and at least one of its employees was enrolled in a health plan obtained through the AHP on or before March 23, that employer's group plan is grandfathered, and any employees of that "grandfathered" employer would be eligible for the "grandfathered" benefits, even if they were added to the coverage after March 23, 2010. However, if an employer joins an AHP and begins enrolling its employees in a health plan obtained through an AHP *after* March 23, 2010, that plan is not grandfathered. The fact that the "master contract" between the

[1] In Washington state, AHPs enter what we term a "master contract" with the carrier, which sets forth the agreement between the association and the carrier and allows the association to offer the carrier's coverage to their members under certain terms. Most associations have only employer members, although a few enroll individuals. The employer members receive certificates of coverage – the actual insurance policies – which they provide to their enrolling employees. Individual members also receive certificates directly from the association.

[2] Partly, our understanding is based on Kevin Lucia's remarks from the call with HHS on September 21, 2010, which the NAIC loosely transcribed and distributed as "notes" to the states.

association and the carrier was in existence on March 23, 2010 and continued thereafter would not affect the grandfathered status of the member's plan.

Financial Reporting

The NAIC recently adopted reporting requirements for the requisite carrier financial filings for the 2010 plan year. The first reports will be due in April 2011. Insurance carriers are required to use the NAIC "blanks" form developed this summer for this reporting. The form requires each health carrier to report its health business experience from 2010 separately as individual, small group, or large group. Again, the NAIC "blanks" form does not contemplate any difference in reporting requirements for AHP plans.

Medical Loss Ratio (MLR) Reporting/Rebating

The NAIC is in its final stages of adopting its Medical Loss Ratio (MLR) Model "*Regulation for Uniform Definitions and Standardized Rebate Calculation Methodology for Plan Years 2011, 2012, 2013 per Section 2718(b) of the Public Health Service Act."* It is our understanding that carriers which insure AHPs will need to report the data required by this model, if adopted by the Secretary of HHS in the manner prescribed by rule, and will need to separate the data between large groups, small groups, and individuals purchasing coverage through the AHP. In other words, the NAIC instructions for reporting the expense experience through the NAIC "blanks" form require that each carrier aggregate and report separately the components of its experience for its individual, small group, and large group plans purchasing through an AHP.

My question is whether HHS interprets the Affordable Care Act as I have outlined above for grandfathering, financial reporting, and MLR reporting purposes.

Because carriers need to know as soon as possible whether they must separate their AHP business into grandfathered/non-grandfathered plans, even though their master contract with the AHPs has not changed significantly since March 23rd, I would appreciate any guidance you can provide. I recognize the workload you are managing, and I appreciate any time you can spare to provide an answer to this important issue.

Sincerely,

Mike Kreidler
Insurance Commissioner