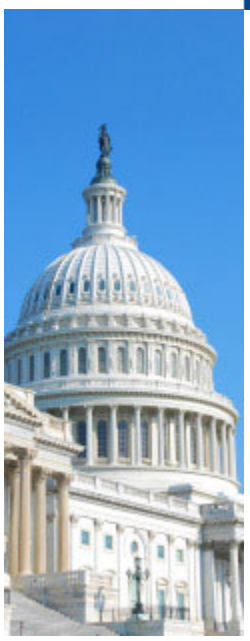
Health Care Reform: Eye on Implementation



Regular updates from Aetna on the implementation of health care reform.

April 1 , 2011

HCR Implementation: A Closer Look at the MLR Requirements

Aetna this week took another step toward complying with the Patient Protection and Affordable Care Act's (PPACA) medical loss ratio (MLR) requirements, among the most complex processes to result from a provision of the law. Specifically, on April 1, we filed Supplemental Health Care Exhibits to demonstrate our ability to comply with the new MLR reporting requirements.

It is important to note that the filing is not an accurate predictor of future MLR results under the law. The filing uses 2010 data and is essentially a "dry run" that shows we are ready and well positioned to successfully meet the reporting requirements. Although the filing does not reflect actual rebate scenarios, it does raise important issues with the law.

Let's review the requirements and what we've learned in more detail.

Getting Ready to Meet the Requirements
Under the law, 2011 Individual and Small Group plans have to spend at least 80 percent of their premiums on medical care and quality improvement. Large Groups plans (more than 100 employees) have to spend at least 85 percent of premiums on those costs.

We'll be calculating those percentages in 2012 once we have the 2011 full year's claim data to analyze. If an insurer does not meet the minimum percentage required under the law for a market, it will have to pay rebates to its customers in that market. We are a long way from knowing whether we will have to pay rebates on any markets next year.

"Dry run" filing completed
The April 1 filings are based on our 2010 plan results and are not meaningful other than they will allow the government to analyze whether all insurers are ready to comply with the law next year.

These filings report the percentage of premiums that were spent on medical care and quality improvement activities in 2010, as defined today under the law. These are not the same definitions Aetna used in the past, so the numbers are not identical to the medical benefit ratio we've released in our 2010 financial statements. The law also defines group sizes differently from Aetna and some of the states. While we have considered Small Group plans to be 50 eligible members and under, the law defines a small group as having fewer than 100 employees. Our filings of 2010 data also reflect

Aetna's previous definition of Small Group (up to 50 eligible employees) and not the definition in the MLR regulations (up to 100 active employees).

It is also important to note that the 2010 numbers included in these filings do not reflect the changes that we put in place after the law was passed last year (e.g., pricing, plan offerings, etc.). Changes to pricing and plans will no doubt alter our experience in 2011.

MLR Issues on the Horizon
MLR reporting is a complex undertaking that required significant investment of time and resources. Aetna has invested more than $30 million in health care reform compliance overall. Ultimately, the MLR rebates will not offset the cost of implementing reform, nor will it slow skyrocketing medical cost increases.

Now that we have the experience of completing the MLR dry run, we need to take the opportunity to participate in improvements to the MLR regulations. We need to allow for the large group employers to be aggregated at a national level to help reduce administrative hassles for companies with employees in multiple states. We also need a broader definition of quality improvement activities to preserve functions that improve quality outcomes and safety. We also need to ensure that investments in fraud prevention and information technology are not jeopardized.

The filings are a reminder that the potential for unintended market consequences due to inappropriate MLR rules is significant.

Individual Market Waivers in the Works
Fearful of the negative impact the MLR requirements could have on the local marketplace, a number of states have already requested or are considering requesting waivers for the Individual market. In fact, Maine already has been granted such a waiver. Eight other states (Iowa, Georgia, Florida, Kentucky, Louisiana, North Dakota, Nevada, New Hampshire) have applied for waivers and at least six more are considering making similar applications.

In her waiver application, Iowa insurance commissioner Susan Voss requested the Individual MLR be ratcheted back to 60 percent for this year.. “For smaller carriers in Iowa, who are on the cusp of credibility, the 80 percent MLR will have a crippling effect on their business model," she said in the filing. Earlier in March, HHS agreed to Maine's request to lower the threshold for the Individual segment to 65 percent for three years after finding that there was a "reasonable likelihood of destabilizing the individual insurance market" if the 80 percent MLR requirement was implemented on schedule in Maine.

Other Implementation News

Internal Claims and Appeals Rules
The Department of Labor has issued guidance on government enforcement of certain internal claims and appeals rules that extends the current grace period, which runs out in July of this year, to plan years beginning on or after January 1, 2012 with respect to four key areas of major insurer and employer concern. The affected areas include the cultural and linguistic notice requirements, disclosure of treatment and diagnostic codes and their descriptions to members, the urgent care turnaround timeframe for initial requests, and the strict compliance standard.

Aetna is concerned that the diagnosis code requirements could be confusing to

members and will be costly and burdensome. All four requirements are no longer subject to a good faith implementation requirement during the enforcement grace period, and the DOL has indicated that an amendment will be issued to the original 2010 interim final regulations in this area. For the rules on which the enforcement grace period expire in July (i.e., other required notices on statements of adverse determinations), implementation will take effect on plans written or renewed beginning July 1, 2011.

HHS is expected to issue future guidance on whether the states' external review processes meet the federal standard for external review. The scope of federal external review process (for self funded, or the federal-operated process applicable to certain insured business) was not addressed by this guidance but may be addressed in the future.

Resources
Be sure to check out our health care reform site off of aetna.com for answers to your questions about health reform. The new site is called Health Reform Connection, and it can help you understand how the PPACA is likely to impact you, as well as what remains to be done to help transform the health care system. Other useful resources include:

The Facts About Rising Health Care Premiums
HealthCare.Gov
AHIP Latest News and Information on Health Reform
American Benefits Council: Health Care Reform