

**Does your company believe it needs additional time to modify business models to best meet the new ACA requirements, and if so, information regarding the nature of contemplated modifications?**

**Relating to item #6 in the October 18, 2011 letter from CMS/CCIIO.**

<b>Issuer</b>	<b>Response</b>
<b>Aetna Life</b>	Overall Aetna expects to meet all of the requirements of our Individual business as promulgated by ACA. The current timing, however, is requiring significant resources and efforts that have the potential to adversely impact business operations and overall service. In order to better support our members and the state, providing additional time to implement the requirements would be in the best interest of all our key stakeholders, especially our members.
<b>American Medical Security</b>	We do believe we need additional time to modify business models to best meet the new ACA MLR requirements. We are still analyzing the need for potential modifications.
<b>BCBS of NC</b>	No, we do not need additional time.
<b>Celtic</b>	No additional time is needed to meet the ACA requirements.
<b>Connecticut General</b>	Connecticut General believes that it needs additional time for its book of business to mature and business model changes to gain traction to best meet the new ACA requirement. Because of the low average duration of Connecticut General's book of business, the book tends to run at a lower MLR than we expect it to run at once the duration reaches a more mature steady state. In addition, the commission adjustments made only impact newly issued policies. Existing policies maintain the commission structure they were originally issued at, therefore it takes time for the commission changes to gain traction in the final results of the business.
<b>Golden Rule</b>	We do believe we need additional time to modify business models to best meet the new ACA MLR requirements. We are still analyzing the need for potential modifications.
<b>Humana</b>	Currently we do not feel that we need additional time to modify business models. As noted in our response to #1, the transition from a lower loss ratio to 80% takes time and a waiver would support the necessary time needed to make expense reductions.

Issuer	Response
<b>John Alden</b>	<p>We need additional time to modify our pricing and expense structure due to the issues described in our response to #1. In addition, although our company has already reduced commissions and taken other expense reduction actions, additional time is needed to evaluate how these changes impact our business and whether and to what extent further expense and/or pricing changes are necessary.</p>
<b>MEGA Life &amp; Health</b>	<p>Prior to PPACA, the minimum loss ratio as defined by the NAIC for the health benefit plans that we historically marketed was 55%, which is significantly lower than PPACA’s 80% requirement. The company feels that it is absolutely appropriate and necessary to allow additional time to modify our business model to account for this dramatic shift.</p> <p>Due to the fact that our company is a smaller nationwide carrier that is not in the large group market, we do not have economies of scale thus our administrative expenses are higher than average. Significant efforts have been made towards reducing administrative expenses over the last 2+ years, but there are many fixed costs, and administering the health benefit plans that we have in force is very labor intensive. In addition, the company has experienced extraordinary administrative costs related to PPACA benefit changes (both in IT related costs and mailing/printing costs) as well as other changes required under PPACA. There are potentially significant costs looming for the ICD-10 conversion and the implementation of the ‘Summary of Benefits and Coverage and Uniform Glossary’ in 2012 and beyond.</p>
<b>Mid West National Life</b>	<p>Prior to PPACA, the minimum loss ratio as defined by the NAIC for the health benefit plans that we historically marketed was 55%, which is significantly lower than PPACA’s 80% requirement. The company feels that it is absolutely appropriate and necessary to allow additional time to modify our business model to account for this dramatic shift.</p> <p>Due to the fact that our company is a smaller nationwide carrier that is not in the large group market, we do not have economies of scale thus our administrative expenses are higher than average. Significant efforts have been made towards reducing administrative expenses over the last 2+ years, but there are many fixed costs, and administering the health benefit plans that we have in force is very labor intensive. In addition, the company has experienced extraordinary administrative costs related to PPACA benefit changes (both in IT related costs and mailing/printing costs) as well as other changes required under PPACA. There are potentially significant costs looming for the ICD-10 conversion and the implementation of the ‘Summary of Benefits and Coverage and Uniform Glossary’ in 2012 and beyond.</p>

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<b>National Foundation Life</b>	The Company is not requesting additional time to modify its business models.															
<b>Time</b>	We need additional time to modify our pricing and expense structure due to the issues described in our response to #1. In addition, although our company has already reduced commissions and taken other expense reduction actions, additional time is needed to evaluate how these changes impact our business and whether and to what extent further expense and/or pricing changes are necessary.															
<b>Wellpath Select</b>	<p>Given the issuance of the MLR interim final rule by the HHS in late November 2010, with an effective date of January 1, 2011 insurers were given very little time to modify our business models and practices to comply with the new standards. In addition, the overall market, including brokers and consumers, had little time to adjust or transition to the new standards. Consequently, there has been a destabilization of the individual market in North Carolina. The Company does need additional time to modify its business model to the ACA's MLR standards in the individual market. Before the MLR regulations became effective in 2011. The Company priced its products to produce an MLR level of approximately 70%, which was appropriate for the historical broker commission levels and types of products being offered at that time. To attain the 80% MLR requirement, the Company needs additional lead time to change from a broker distribution system to an internet/direct distribution system and will also need to revamp product offerings. Furthermore, certain benefit designs that generate a higher degree of administrative costs as a percentage of premium and/or are offered at a lower price point will no longer be viable given the 80% MLR requirement. Consider, for example, the Qualified High Deductible (QHD) product illustration below that compares our most affordable product, Plan 19A, with our richest QHD plan, Plan 7A. The illustration is as follows:</p> <table border="1" data-bbox="378 1036 1396 1226"> <thead> <tr> <th data-bbox="378 1036 829 1073"><u>Product</u></th> <th data-bbox="829 1036 1207 1073"><u>QHD Plan 19A</u></th> <th data-bbox="1207 1036 1396 1073"><u>QHD Plan 7A</u></th> </tr> </thead> <tbody> <tr> <td data-bbox="378 1073 829 1110">Premium</td> <td data-bbox="829 1073 1207 1110">\$97.33</td> <td data-bbox="1207 1073 1396 1110">\$201.43</td> </tr> <tr> <td data-bbox="378 1110 829 1148">Medical (80%)</td> <td data-bbox="829 1110 1207 1148">\$77.86</td> <td data-bbox="1207 1110 1396 1148">\$ 161.14</td> </tr> <tr> <td data-bbox="378 1148 829 1185">Available for Administration</td> <td data-bbox="829 1148 1207 1185">\$19.47</td> <td data-bbox="1207 1148 1396 1185">\$40.29</td> </tr> <tr> <td data-bbox="378 1185 829 1222">Members at September 2011</td> <td data-bbox="829 1185 1207 1222">1,515</td> <td data-bbox="1207 1185 1396 1222">89</td> </tr> </tbody> </table> <p>This illustration is just one example of an attractive low-price product (Plan 19A) that will likely be removed from the North Carolina market and unavailable to consumers without a waiver due to insufficient funds available for product administration. We simply will be unable to offer a product on a continued basis that provides less than \$20 per member per month for total administrative services, including commissions, and does not cover its costs. However, we believe</p>	<u>Product</u>	<u>QHD Plan 19A</u>	<u>QHD Plan 7A</u>	Premium	\$97.33	\$201.43	Medical (80%)	\$77.86	\$ 161.14	Available for Administration	\$19.47	\$40.29	Members at September 2011	1,515	89
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	that the proposed federal adjustments as submitted by the Department to HHS would be sufficient to keep those products available to consumers by allowing for orderly changes in business practices without undue disruption to and destabilization of the individual marketplace.