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May 14, 2010

Mr. Donald B. Moulds
Acting Assistant Secretary for Planning and Evaluation
Office of the Secretary
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington D.C. 20201

Re: DHHS-2010-MLR, Medical Loss Ratios; Request for Comments Regarding Section 2718 of the Public Health Service Act

Submitted via Federal e-Rulemaking Portal: www.regulations.gov

Dear Mr. Moulds:

America's Health Insurance Plans ("AHIP") welcomes the opportunity to respond to your Request for Information ("RFI") published in the Federal Register on April 14, 2010 regarding Medical Loss Ratios ("MLRs") found in Section 2718 of the Public Health Service Act ("PHS Act") as enacted in the Patient Protection and Affordable Care Act ("PPACA"). Section 2718(a) of the PHS Act entitled "Bringing Down the Cost of Health Care Coverage" requires health insurance health plans offering individual or group coverage to submit to the Secretary an annual report "concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums" ("PPACA MLR").

AHIP is the national association representing nearly 1,300 member companies providing health, long-term care, dental, disability, and supplemental coverage to more than 200 million Americans. Our members also participate in Medicare, Medicaid, and other public programs. Our community is strongly committed to the successful implementation of PPACA, and welcomes the opportunity to bring transparency to the components of health care costs.

Fundamental Guideposts for Implementation

There is widespread agreement among health care experts, stakeholders, and policymakers that our nation needs to move to a 21st century, evidence-based health care system that promotes quality, rewards value, and incentivizes prevention and wellness. In fact, as part of the new health care reform law, policymakers are experimenting with new quality initiatives in Medicare,

such as patient-centered medical homes, medication management programs, pay-for-quality initiatives, and the development and maintenance of high-quality, accountable provider networks.

Health plans have pioneered these important initiatives. Patients today rely on health plans' care coordination, disease management, continuous quality improvement, prevention, and wellness programs. These programs have yielded significant results in improving health outcomes, reducing medical errors, reducing complications, and enhancing patients' quality of life. In addition, many health care experts believe that by improving health outcomes and advancing quality care, these programs and services will also help to reduce the long-term growth rate of health care costs.

As policymakers develop the new MLR requirements, we believe there are two essential goals that should be pursued:

1) Minimize disruption for families and employers purchasing health insurance coverage (which is a particular risk during the transition to the 2014 market reforms); and

2) Preserve patients' access to health plan programs and services designed to improve health care quality and meet individual patient needs.

Our comments below are structured as follows:

Section 1. We explain why the goals stated above need to be a top priority given the potential impact these regulations could have on patients. We explain what medical loss ratios are and what they are not, and outline the consequences of potentially disrupting existing coverage and discouraging investments in various care management and related programs.

Section 2. We outline the need for a smooth transition to a post-2014 reform environment and long-term stability. We also suggest the key elements that any such transition must address to be effective, and discuss the importance of addressing "special circumstances" as the statute requires.

Section 3. We reference the important work of the Institute of Medicine (IOM) and Agency for Healthcare Research and Quality (AHRQ) to provide a framework for categorizing activities that improve health care quality. In addition, we provide detailed examples of the types of initiatives that must qualify as such activities if the nation is to advance toward higher health care quality that is consistent with the aims outlined by IOM and AHRQ, and resident in various major provisions of PPACA.

Section 4. We highlight various issues related to the administration of Section 2718 and encourage an approach that avoids substantially increasing administrative costs due to onerous new administrative requirements related to complying with Section 2718's reporting and rebating obligations.

Section 5. Given the complexity of implementing this provision and the need to have industry stakeholder input on a variety of technical details, we recommend that HHS follow the proposed rulemaking process. This will ensure that a stable transition is adhered to as plans work to meet the requirements revealed through the regulatory process. We also recommend in this section that HHS make the scope of the MLR provision clear.

Finally, we provide specific responses to a number of the questions outlined in the RFI.

Section 1: Understanding MLRs and the Potential Risk of Creating Disruption and Inhibiting Advances in Quality

The risk of unintended consequences is especially high as it concerns the regulatory implementation of Section 2718. Historically, the MLR's primary purpose was to provide a measure for assessing financial solvency and determining whether proposed rate increases were appropriate given growth in underlying medical costs, particularly with respect to indemnity-based insurance models.

As Professor James Robinson plainly put it in a *Health Affairs* article published over a decade ago: "The medical loss ratio is not a straightforward indicator of either medical or administrative expenditures. It certainly is not a measure of clinical quality or social contribution."[1]

The history and admonitions over what MLRs are and what they are not provide important context for the implementation of Section 2718. There is potential for disruption in coverage given that this provision is geared toward the post-2014 environment which is expected to differ significantly from the current market as explained below. Absent an appropriate transition, as the American Academy of Actuaries has pointed out, the result could be a loss of coverage and a narrowing of choices and lessening of competition more generally.

The second principal risk is that the term "activities that improve health care quality" will be construed in a way that is either too narrow or static. This would take us off the course of creating a 21st century health care system and create new barriers to investment in the many activities that health plans have implemented for the primary purpose of improving health care quality. This would turn back the clock on progress toward reform since both the AHRQ and the IOM have long recognized that there are multiple components or facets to health care quality and that the goal is to provide patient-centered care that is appropriate, safe, timely, and effective.

[1] Robinson, James. "Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance." *Health Affairs,* Volume 16, Number 4, p. 186.

Factors Needed to Facilitate a Smooth Transition

There is a need for a clear process for MLR calculations that ensures stability in coverage during the crucial transition to the 2014 market reforms. This is borne out by an examination of how the current market differs from what the market is to look like post-2014.

In practice, Section 2718 assumes the existence of new infrastructure and market rules that will not be in place when the MLR is implemented. This necessitates the need for clear steps that ensure a transition that does not cause instability and disruption in the marketplace.

Comparing the Current vs. Post-2014 Environment

- **Durational related issues for individual coverage.** In contrast to the post-2014 environment, the current market is voluntary in nature. This has significant implications for the calculation of MLRs for individual coverage. Approximately, 85% of those with existing individual coverage reside in states where individual coverage is provided on an underwritten, guaranteed renewable basis. This creates a "durational" dynamic where loss ratios are low in the early years of coverage and then rise significantly in later years. Consequently, the relevant NAIC model and most states provide that loss ratios are to be filed on a "lifetime basis" along with a schedule of yearly targets signifying whether coverage is on track to comply with the lifetime target.

- **Labor intensive processes for offering new coverage in the individual and small group markets.** Absent an alternative distribution system, such as is called for with creation of the state-based exchanges in 2014, coverage obtained in both the individual and small group markets is heavily reliant upon the use of brokers and agents to help individuals find coverage options that best suit their needs. In these markets, brokers perform the functions that human resource managers provide for larger employer groups. This, in addition to the fact that initiating coverage on a one-by-one or smaller scale basis for individual consumers and smaller employers is time and labor intensive, helps to explain the initial high costs associated with providing coverage in these markets – whether for individuals or small businesses.

- **Fixed nature of certain administrative costs makes the proportion of premiums spent on administration seem high in the case of lower cost products or markets.** Because administrative costs are often of a fixed nature and the MLR reflects a simple ratio of certain categories of spending relative to premiums, administrative costs will make up a larger proportion of the premium in the case of lower cost products or markets. This is despite the fact that in absolute value terms, these expenses may be on par with those associated with higher cost products or markets. This can have a particularly large impact on individual coverage where the average cost of coverage is approximately 40 to 50 percent less than the cost of large group coverage.

- **Cost structure related to existing coverage and the impact of contractual obligations that remain in force.** Coverage in place today generally reflects existing state MLR requirements that are significantly different than those set out in PPACA along with cost structures and ongoing contractual obligations that were entered into long before passage of PPACA and that cannot be altered. This has significant implications for the stability of existing coverage in the individual and small group markets.

- **Impact of lower overall premium levels on MLR values.** Another major differentiator between the pre-2014 and post-2014 environments is that post-2014, plans will be required to meet certain actuarial values that inherently implies greater spending on medical expenses, as well as higher premiums as the Congressional Budget Office has pointed out. This will lead to higher MLRs in the post-reform environment, particularly in the case of individual coverage and in many cases for group coverage.

  Related to this issue, it should be noted that health plans cannot simply raise the actuarial value of their current offerings. Doing so will raise premiums – which most customers would oppose – and financial assistance is not available for individuals and families until 2014.

Section 2. Key Components for a Smooth and Effective Transition to the 2014 Environment and Long-Term Stability

The significant differences between the current market and that expected for 2014 underscores the importance of ensuring an effective transition. There is simply no viable way given these differences to move between the current system to the post-2014 reform environment without creating significant disruption in coverage, absent planning and provisions to provide for a smooth transition.

An effective transition would take account of the factors highlighted above with respect to the differences between the current and post-2014 markets, and ensure that these factors are addressed through the development of uniform methodologies and definitions required to compute the MLR ratios. In this regard, we believe it would be appropriate for a graduated path to the 2014 market reforms as a means of encouraging stability in coverage during the transition.

Maintaining Long-Term Stability in Coverage

Another important consideration for ensuring that implementation of the MLR provision does not create instability in coverage is the approach or methodology for pooling costs and experience with respect to the provision of coverage. This is a critical issue both with respect to the transition to 2014, and for the longer-term.

The essential issue is to arrive at an approach that ensures costs accounted for under the MLR calculation match the actuarial considerations involved in pricing coverage. To do otherwise is to break with well-established accounting principles that seek to match costs with associated revenues. This could lead to volatile results if the costs pooled for purposes of the MLR calculation reflect an artificial subset of the costs actually taken into account in establishing actuarially sound rates. The following provides a summary of our key recommendations to ensure that these principles are taken into account:

1. *Approach for Calculating the MLR Ratio:* Given that PPACA recognizes the important interest in maintaining an effective system of state-based insurance regulation, we support a state-based approach under which a loss ratio would be calculated for each insurance holding company group in each of the three market segments – large group, small group and individual. We also support making appropriate actuarial or statistical adjustments where the scale of enrollment being taken into account in the MLR calculation could create unintended volatility that drives up the cost of coverage for consumers and reduces available choices in the market.

   In addition, the particular challenges of large employers should also be taken into account. Large employers often have multiple work sites and employees in many states. Reflective of this structure, carriers do not generally report MLR information on a state-by-state basis. Consequently, requiring carriers to calculate the MLR for large groups using the same precise rules as those for individual and small group coverage could result in significantly higher administrative costs at a time when carriers are being required to hold these expenditures to a minimum.[2]

2. *Creditability Adjustment:* As noted, any solution to address these concerns should ensure accurate distribution of administrative expenses and conform calculation of the MLR with the accounting principle of matching costs to associated premiums. It should also recognize the need to ensure appropriate levels of statistical credibility as explained below.

   Also critical to maintaining stability in coverage is to recognize that blocks of individual and group policies may be credible for MLR calculation purposes, that is, may have sufficient scale, at the national level but not at the state level, or they may be credible in some states, and not credible, that is, may not have sufficient scale, in others, or they may be credible within one reporting entity and not in another affiliate.

[2] The issues to be addressed in considering the circumstances of large-group coverage have been recognized elsewhere. According to the economist James Robinson, "This obscure statistic [the MLR] is losing whatever meaning it once had." He notes one particular issue with the MLR as: "Efforts to compute the medical loss ratio for any one geographic region require the parent company to allocate central administrative expenses to particular regions. This is particularly problematic when some products, such as those for federal employees or large corporations, are marketed and managed at the national level." (Robinson, James. "Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance." *Health Affairs,* Volume 16, Number 4, p. 176-187.)

One way to address this issue is to adopt a modified version of the credibility adjustment table that is included in the NAIC Annual Medicare Supplement Refund Calculation form adjusted for a non-Medicare Supplement population. The new MLR standards must guard against the unintended effect of causing volatility that results from normal variation in experience, and that could drive up the cost of health insurance coverage for consumers and reduce their choices in the marketplace. New regulations should build on the experience and lessons learned from the calculations designed for the NAIC Medicare Supplement loss ratio standards. However, the specific standard adopted for the commercial health insurance market would need to be adjusted to factor in the diversity and wider variation of claims costs experienced in comprehensive benefit plans for a non-Medicare Supplement population.

The NAIC methodology addressed some of the claim variation by adopting a credibility or tolerance adjustment to the MLR based on the number of policyholders and the length of time they held their policies. Adjustments decrease as the number of policyholder years increases.

If a credibility adjustment is not included in the MLR calculation, it will result in unstable premium rates due to claims volatility, and the possibility of large premium increases as the policy experience matures. In addition, claims volatility could cause a health plan's experience to fall below the MLRs minimum, leading to the payment of rebates and generation of financial losses solely because of volatility in experience (without any corresponding offsets in years where the experience is above the MLR threshold due to the same volatility).

This dynamic could create solvency issues for health plans, forcing plans to exit the market or discouraging them from entering new states. Similarly, the ability to offer new products would also be compromised unless a minimize size threshold for MLR credibility purposes is devised. The overall impact of these negative, unintended effects would be to leave consumers with less affordable coverage options due to the lack of market competition, and to risk disrupting coverage for existing policy holders.

Taking Account of Special Circumstances

The statute specifically requires that the NAIC, in creating the uniform definitions and methodologies, take into account the "special circumstances" of "smaller plans, different types of plans, and newer plans." As Congress recognized, taking account of these special circumstances is critical to ensuring that consumers continue to have access to a range of coverage choices, that competition is fostered with the entry of new plans, and those who obtain their coverage through a smaller plan are able to retain it without risk of disruption.

The special circumstances at issue here largely relate to the points raised above, and the need to address these special circumstances is particularly critical during the transition to the 2014 market reforms:

- *Newer Plans:* As discussed, individual health care coverage typically reflects lower loss ratios in the early years or "durations" of coverage and higher loss ratios in later durations. Coverage in both the individual and small group markets reflect significant start-up costs. In addition, in many cases, the coverage under newer plans may be in place for less than a year and will not have accumulated adequate experience for purposes of the MLR calculations. Approaches for addressing the special circumstances of "newer plans" need to take these factors into account.

- *Different Types of Plans*: There are a number of potential issues that need to be addressed, including circumstances involving the provision of coverage to Americans located abroad.

  Another special circumstance to recognize is that coverage issued prior to enactment of PPACA was designed to meet different standards, and the cost structure for this coverage is locked in through contractual commitments. Similarly, as discussed, the differences between the current market and post-2014 market should be taken into account with respect to coverage issued during the 2010-2014 transition. In other words, while the requirements of the MLR provision remain largely unchanged between the pre and post-2014 time period, implementation of the major structural changes does not occur until after 2014.

- *Smaller Plans:* The issues associated with scale are particularly important for smaller plans. In this regard, the credibility adjustment discussed above is especially necessary as a means of protecting small plans against volatility in the market and effectively creating a barrier to the entry of new plans – which will tend to be small at the outset.

  In addition, smaller plans also face challenges with respect to the structure of administrative costs. Because many administrative costs are fixed in nature, smaller plans will tend to have higher average administrative costs because they have a smaller base of coverage over which to spread these costs.

It is also important to take into account the tendency for each of these circumstances to run together. For example, if a particular carrier offers coverage that is predominantly "new," or in early durations, "small" with respect to scale, and "different" reflecting the rules and structure of the market under which the coverage was written, the totality of these circumstances should be taken into account. To do otherwise is to invite significant disruption for those with existing coverage and to limit choices and competition for all consumers.

Section 3. Establishing Uniform Definitions and Methodologies: It is critical that, as the ratio is developed, its "uniform definitions" and "standardized methodologies" should not be structured in a way that: (1) harms consumers by reducing choice among health plans or providers; (2) diminishes the solvency of health plans; or (3) interferes with the provision of health care benefits through high quality providers. The PPACA MLR will not meet these goals

if the process for the PPACA MLR fails to recognize full case experience and transition issues or penalizes health plans for their quality related activities or for their bundled payment innovations.

Reporting under § 2718(a) of the PHS Act

Unlike loss ratio reporting that health insurance health plans currently provide to some states, PPACA creates new categories to be reported for existing costs. Specifically, Section 2718(a) requires the report to include percentage of premium dollar expenditures "(1) on reimbursement for clinical services provided to enrollees under such coverage; (2) for activities that improve health care quality; and (3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding State taxes and licensing or regulatory fees." For true transparency, there should be a clear understanding of the parameters for each of the categories dictated by PPACA.

"Reimbursement for clinical services provided to enrollees"

For purposes of calculating the MLR, it would appear that the term "reimbursement for clinical services" would include any payment for the provision of clinical services. However, with the implementation of many new innovations in health care delivery, reimbursement for clinical services is increasingly in the form of a bundled payment that may include secondary health care improvement components. In light of the various provisions of PPACA that seek to achieve appropriate care patterns, AHIP recommends MLR standards and uniform definitions that allow bundled payments by the health plan to the provider to be included in total as a cost of "reimbursement for clinical services." While portions of these bundled payments include quality improvement mechanisms, we recommend that including all such payments as "reimbursement for clinical services" will alleviate the unnecessary burden in accounting for such payments and encourage health insurance health plans and health care providers to promote such bundled payment arrangements which help patients get the appropriate care and may help bring down the cost of health care coverage.

"Activities that improve health care quality"

With respect to the second broad goal of ensuring that our nation's health care system moves toward a higher value path focused on quality, it is critical that the term "activities that improve health care quality" as referred to under PPACA Section 1001 (amending PHSA, Section 2718), is appropriately defined. This definition should recognize the full range of health plan activities – both directly and indirectly related to patient care – that have the primary purpose of improving patient outcomes.

When defining such activities, HHS should consider the quality framework and criteria established by the Institute of Medicine (IOM) and the Agency for Healthcare Research and Quality (AHRQ), entities which have a primary goal of promoting high quality health care for consumers. In *Crossing the Quality Chasm*, the IOM stated that enhancing quality in our health

care system requires a focus on six core aims: (1) safety; (2) effective; (3) patient-centered; (4) timely; (5) efficient; and (6) equitable. AHRQ – which consistently refers to the IOM's criteria – notes that there are similar facets to health care quality. More details about the IOM and AHRQ quality framework and criteria are included in Appendix A.1.

Identifying Categories of Activities that Improve Health Care Quality

We believe the definition of "activities that improve health care quality," at a minimum, should include:

- Care and case management, disease management programs, care coordination and patient monitoring that provide direct benefits to policyholders;

- Wellness and prevention programs including health risk assessments;

- Investments in health information technology that are designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care, including the development of personal health records (PHRs) and costs associated with the transition to ICD-10 codes that will be used in health plan systems that promote quality and safety;

- Costs associated with provider credentialing, ensuring that providers are appropriately accredited, certified, licensed, and have not committed malpractice, fraud, or other violations, and other activities related to the development and maintenance of networks (including Centers of Excellence networks);

- Quality programs that would qualify a plan for accreditation by either URAC or NCQA;

- Value-based purchasing initiatives, including pay-for-quality, gain-sharing, risk sharing arrangements, and shared savings initiatives, intended to provide higher quality of direct care to patients;

- Nurse call lines;

- Care improvement activities that aim to improve the quality and/or appropriateness of care delivery at either a population or service level, including medication therapy management, radiology benefit management, and formulary management;

- Programs designed to ensure patient safety with respect to prescription drugs, such as medication and care compliance, drug interaction, and drug safety programs;

- Quality research and reporting programs designed to educate providers and encourage them to change behavior to improve patient outcomes;

- Consumer education programs, including programs aimed at reducing health care disparities;

- Costs associated with maintaining and developing patient-centered medical homes; and

- Internal and external review programs that ensure that patients receive effective care in a timely manner.

We believe the activities listed in the bullets above are appropriately identified as "activities that improve quality of care" for the following reasons:

- All of the activities are consistent with the IOM's and AHRQ's criteria for quality care;

- Many of the activities have been referred to as quality improvement activities in the health care reform law;

- Activities have been referred to as quality improvement activities by the Administration, and/or by independent and credible groups; and

- There are numerous examples of how these activities have improved health care quality for patients.

These reasons are explained in more detail below and in Appendix A.2.

Consistent with the IOM and AHRQ Criteria for Quality Care

Each of the activities listed in the bullets above meets *at least one* of the facets contained in the IOM's definition of quality, and/or contributes to ensuring quality health care based on AHRQ's criteria (i.e., that the right thing is done for patients at the right time and care is effective). For example:

- Activities listed above which improve patient safety (IOM's first criteria) include: investments in health information technology to reduce medical errors and patient safety programs including programs that prevent adverse drug interactions.

- Activities listed above which improve effectiveness of care and help avoid underuse, overuse, and misuse (IOM's second criteria and AHRQ's criteria) include: wellness and prevention programs, provider credentialing and activities relating to the development and maintenance of provider networks, quality programs that would qualify a plan for accreditation, value-based purchasing initiatives, internal and external review programs, nurse call lines, care improvement programs, and quality research and reporting programs designed to educate providers.

- Activities listed above which improve patient-centeredness (IOM's third criteria) include: patient-centered medical homes, and care and case management and disease management programs.

- Activities listed above which improve equity of care (IOM's sixth criteria) include: consumer education programs including programs to address health care disparities.

Referred to as Quality Improvement Activities in PPACA

Many of the categories of activities listed above have been referred to as quality activities in the health care law. These activities include:

- Quality reporting (See PPACA, Section 1001);
- Effective case management (See PPACA, Section 1001);
- Care coordination (See PPACA, Section 1001);
- Chronic disease management (See PPACA, Section 1001);
- Medication and care compliance initiatives (See PPACA, Section 1001);
- Patient-centered education and counseling, comprehensive discharge planning, post discharge reinforcement by an appropriate health care professional, and other activities to prevent hospital readmissions (See PPACA, Section 1001);
- Activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage (See PPACA, Section 1001);
- Wellness and health promotion activities (See PPACA, Section 1001);
- Value-based purchasing initiatives, such as pay-for-quality initiatives (See PPACA, Title III, Subtitle A, Part I);
- Patient-centered medical home (See PPACA, Section 3502);
- Care improvement activities, such as medication management (See PPACA, Section 3503); and
- Activities related to the development and maintenance of provider networks, such as maintenance of certification (See PPACA, Section 10327)

More detailed information is provided in Appendix A.2.

Referred to as Quality Improvement Activities by the Administration and Others

Many of the categories of activities listed above have been referred to as quality activities by the Administration or other independent and credible researchers or groups. For example:

- ***Personal Health Records (PHRs), Transition to ICD-10 Codes and Other Investments in Health Information Technology.*** OMB recently noted that "the [President's] Budget includes $110 million for continuing efforts to strengthen health IT policy, coordination, and research activities. Combined with the Recovery Act's Federal grant and incentive programs designed to assist providers with adoption and meaningful use of electronic health records,

these efforts will improve the quality of health care while protecting privacy and security of personal health information."[3]

Likewise, the American Academy of Pediatrics ("AAP") has stated that PHRs can "provide information to serve as the basis for pediatric quality improvement efforts." Finally, HHS has indicated that with the adoption of the ICD-10 code sets, the nation is "taking a giant step forward toward developing a health care system that focuses on quality and affordability through the implementation of health information technology… The greatly expanded ICD-10 code sets will enable HHS to fully support quality reporting, pay-for-performance, bio-surveillance, and other critical activities" and "improve disease tracking and speed transition to an electronic health care environment."[4] As HHS recognizes, the new ICD-10 codes will be used by health plans in systems that promote health care quality, including case management applications that capture and review medical history and claims data to help in the coordination of care, disease management processes that evaluate treatment provided to a patient with a chronic condition to ensure that proper care is rendered; pharmacy system processes such as medication warning and allergy alerts; and electronic and personal health record systems.

- ***Activities Related to the Development and Maintenance of Provider Networks.*** Health plans and health plans ensure that providers are appropriately licensed, certified, and accredited as they develop and maintain their provider networks. Such activities have been found by others, such as the IOM, to improve health care quality. The 2001 Institute of Medicine's landmark report, *Crossing the Quality Chasm*, recommended that setting and enforcing explicit professional and facility standards through regulatory and other oversight mechanisms, such as licensure, certification, and accreditation, define minimum threshold performance levels for health care organizations and professionals.

  Health plans also promote high quality by ensuring that network providers have not committed malpractice, fraud, or other violations. The relationship of fraud activities to quality, for example, was confirmed in President Obama's HHS Budget message where "reducing fraud, waste, and abuse" is cited as "an important part of restraining spending growth and providing quality service delivery to beneficiaries."

- ***Care improvement activities.*** These activities are designed to ensure that patients are receiving the right services and procedures at the right time. In a recent report, the Government Accountability Office (GAO) recommended that the Centers for Medicare and Medicaid Services (CMS) use private payer management strategies to address quality issues,

[3] "Secure and Affordable Health Care for All Americans. OMB fact sheet, available at www.whitehouse.gov/omb/factsheet_key_health_care/.

[4] "HHS Proposes Adoption of ICD-10 Code Sets and Updated Electronic Transaction Standards," News Release, August 15, 2008, available at www.hhs.gov/news/press/2008pres/08/20080815a.html.

such as variations in imaging use across geographic regions and potential overuse of imaging services.[5]

Examples Demonstrating the Quality Benefits of these Activities to Patients

Plans and health plans have developed and implemented countless initiatives aimed at improving health care quality and patient outcomes. Several examples are included in Appendix A.2. Each example – which falls into one of the categories listed in the bullets above – includes results which demonstrate how consumers have benefitted from the activity.

In addition to the 13 categories of activities previously outlined, we urge HHS to consider that all carriers fund efforts to improve the health and welfare not only of their enrollees, but of the communities they serve through community benefit programs, such as research, community-based health partnerships, direct health coverage for low-income families, and grants and technical assistance to community clinics, health departments, and public hospitals. These programs improve health care quality and should be recognized as such in the MLR calculation as well.

Moreover, it is important to recognize that the list of activities that improve health care quality is never static. Health plans continue to develop new methods to improve patient outcomes and current quality improvement programs continue to evolve. For this reason, we urge HHS to make clear that any list – which establishes categories of activities that improve health care quality – should not be exclusive. The flexibility to recognize other activities, particularly future activities, as improving health care quality is critical in a constantly changing environment.

Recognizing these or similar activities and factors in the MLR calculation would be consistent with current medical loss ratio calculations of others, such as the state of Minnesota.[6] More importantly, it would create incentives for plans and health plans to continue to promote innovation, and ensure that such programs which improve quality and patient outcomes are developed and maintained. Finally, excluding these activities from the MLR calculation would undermine the quality framework established by the Institute of Medicine and in most cases, the policy objectives of and/or statements made by the Administration.

Section 4. Administrative Aspects of Implementing Section 2718

We offer several recommendations related to the administrative aspects of implementing the MLR provision. The aim of these recommendations is to suggest approaches that result in

[5] GAO-08-452.

[6] Among other things, the state recognizes case management activities, clinical quality assurance and other types of medical care quality, improvement efforts, and consumer education for health improvement in its calculation. Report of 2005 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets for: Insurance Companies Nonprofit Health Service Plan Corporations and Health Maintenance Organizations, June 2006.

effective implementation while seeking to protect against the risk of materially increasing the administrative costs that plans will have to incur in complying with the provision.

Base the MLR Calculation on a Calendar Year: Similar to the model used for the Medicare Supplement program we recommend use of calendar year calculations. A calendar year approach has the advantage of being simpler for consumers to understand. It also better synchronizes with the structure of the vast majority of major medical coverage that includes a deductible and which applies the deductible on a calendar year basis. Moreover, a calendar year approach should not impair reporting or rebating required under Section 2718 given that where the distribution of non-calendar year policy issue and renewal dates are evenly distributed and do not change from one calendar year to the next, the use of a calendar year date creates a reasonable 12 month approximation. By contrast, using an employer group or "ERISA" plan year as the basis of the twelve month period to calculate the MLR will create additional reporting subsets leading to an increase in administrative costs. It could also unnecessarily complicate the MLR calculation and potentially increase the amount of time until a base of statistically credible experience is reported and becomes the basis for potential rebates.

Create a De Minimus Standard: The Medicare Supplement model has refund requirement if plans do not meet certain MLR requirements. However, the refund amount is subject to a *de minimis* standard. This standard recognizes that in some cases the administrative costs associated with processing and distributing a rebate can be more costly than the value of the rebate itself. A similar principle should be established and adopted as part of implementation of Section 2178.

Require Payment of Any Rebates to the "Policyholder": Building again off the Medicare Supplement model we recommend that any rebate be paid to the policyholder. In the group market this will generally mean the employer, with the rebate then being allocated between the employer and employees in proportion to the percentage of premiums each pays. In the non-group market, the policy holder is typically an individual. For administrative simplicity, rebates should also be permitted to take the form of premium credits.

Section 5. Follow the Proposed Rulemaking Process To Receive Necessary Public Input and Provide Appropriate Clarity in Scope

We encourage the Secretary to use the proposed rulemaking process instead of issuing regulations in interim final form. There is sufficient time to allow for notice and comment procedure, this process is vital and necessary to a successful implementation of Section 2718, and the interests of the public are best served by allowing for transparency and meaningful opportunity for public input. Consequently, the process for proposed rulemaking should not be waived.

Our comments reflect the application of the medical loss ratio provision to major medical, comprehensive coverage sold in the individual and group coverage markets recognizing that the

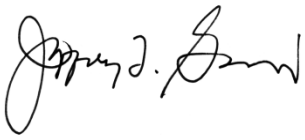
insurance market reforms in PPACA address major medical, comprehensive health insurance coverage and not excepted benefits under HIPAA. In this regard, any regulation or guidance should be clear as to this scope.

As reflected in the RFI, the implementation of the MLR involves many different factors and variables. This is a very technical and complex area that has a significant impact on consumers, employers, and "health insurance health plans" for the group and individual markets. As a result, it is critical that the public receive as much advance notice as possible of the Secretary's proposed rulemaking to establish and implement the process and rules under which the MLRs will be calculated. This, in turn, will ensure that the Secretary has sufficient time to fully digest and consider comments. If the less deliberative interim final rulemaking with a comment period is utilized, then the Secretary should include some time period endpoints so that there is review by the relevant agencies of the filed comments and subsequent final rulemaking. Any interim final rules should be considered a temporary gap measure toward final rulemaking and not remain as interim final for any extended period of time.

Conclusion

Thank you for considering our comments on these critically important issues. We stand ready to work with the Administration, Congress, and other stakeholders to promote the successful implementation of PPACA while minimizing disruption for consumers and employers. Please feel free to contact Gary Bacher, Senior Vice President, at (202) 778-3299 or gbacher@ahip.org if we can provide additional information or technical assistance.

Sincerely,



Jeffrey L. Gabardi
Senior Vice President

Attachments