THE COUNCIL
of INSURANCE
AGENTS & BROKERS

NATIONAL ASSOCIATION
OF INSURANCE AND
FINANCIAL ADVISORS

May 14, 2010

<u>Via electronic transmission</u>

U. S. Department of Health and Human Services
DHHS-2010-MLR
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Medical Loss Ratios; Request for Information Regarding
Section 2718 of the Public Health Service Act (Pub. L. 111-148)
Federal Register, Vol. 75, No. 71, April 14, 2010

The combined membership of our organizations represents more than 500,000 professional health insurance advisors, agents, brokers, consultants and employee benefit specialists, and looks forward to being a constructive part of health reform implementation. Our members service the health insurance and benefit needs of large and small employers as well as people seeking individual health insurance coverage. Every day, they work to obtain insurance for clients who are struggling to balance their desire to purchase high-quality and comprehensive health coverage with the reality of rapidly escalating medical treatment costs. As such, one of our primary goals is to do everything we can to promote access to affordable health insurance coverage.

Professionally licensed and trained benefit specialists help millions of consumers by guiding them through the complexities of health insurance purchasing and enrollment, while ensuring they get the best policy at the most affordable price. They seek to understand each personal situation to create recommendations that complement a client's financial and medical security needs. And our members' job does not end with the sale. Our licensed producers help their clients with claims issues, service questions, and quality enhancement and compliance matters throughout the life of each policy they sell.

The clients of our membership range from Fortune 500 companies to mom-and-pop businesses and individuals seeking health insurance. Our members have a unique understanding of consumer health care needs, of the perspective of business owners and of the economic realties of health insurance markets. They not only sell traditional health insurance products, but also coverage such as dental, long-term care, disability, Medicare Advantage and Medicare Supplements and a variety of consumer-driven products. Our members are also professionally licensed and credentialed, carry errors and omissions insurance and agree to abide by ethical standards which require them to always make health care coverage recommendations with the customer's best interest in mind.

The Department's request for information regarding Medical Loss Ratios (MLRs) in Section 2718 of the Public Health Service Act (in 45 CFR Parts 146 and 148) is of particular interest to the professional benefit specialist community. Our members' interest in crafting sound public policy in this area stems from their commitment to furthering the key goals of health reform in the areas of quality improvement and affordability, enhancement of insurance market competition and administrative efficiencies.

While we strongly support the goals of reducing health care costs, improving health outcomes for patients and providing better value for health care consumers, we are extremely concerned that narrow MLR definitions would adversely impact spending on such important health plan activities as case management, wellness, disease management, and fraud and abuse prevention programs, among others. These important aspects of medical care and health plan coverage were given heightened emphasis by Congress in the PPACA because they both improve care quality and also help contain medical treatment costs. If they are somehow diminished due to narrow MLR definitions and enforcement, the quality of care delivery for consumers will deteriorate and health care costs will surely increase.

The National Association of Insurance Commissioners' (NAIC) accounting rules pertaining to MLRs define "medical loss" as the value of medical claims an insurer actually paid ("incurred claims"), plus the amount of money the insurer sets aside to pay future claims ("contract reserves"). But the new Sec. 2718 of the Public Health Service takes a broader view of MLRs. The new federal requirements provide for health insurance issuers offering group or individual coverage to report publically the percentage of total premium revenue—after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance—that the coverage spends:

- On reimbursement for clinical services provided to health plan enrollees;
- For activities that improve health care quality; and
- On all other non-claim costs, including an explanation of the nature of these costs, and excluding Federal and State taxes and licensing or regulatory fees.

Beginning January 1, 2011, health insurance issuers offering group or individual health insurance coverage must—with respect to each plan year—provide an annual rebate to each enrollee under such coverage if the ratio of: (1) The amount of premium revenue the issuer spends on reimbursement for clinical services provided to enrollees and activities that improve health care quality to (2) the total amount of premium revenue for the plan year (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance) is less than:

(1) 85% for coverage offered in the large group market (or a higher percentage that a given State may have determined by regulation); or

(2) 80% for coverage offered in the small group market or in the individual market (or a higher percentage that a given state may have determined by regulation), except that the Secretary may adjust this percentage for a state if the Secretary determines that the application of the 80% minimum standard may destabilize the individual market in that state).

Section 2718(b)(2) requires that in determining these minimum percentages, states shall seek to ensure adequate participation by health insurance issuers, competition in the state's health insurance market, and value for consumers so that premiums are used for clinical services and quality improvements.

Health Care Quality and Cost Issues

Question 3(b) in Subsection B asks what, if any, lists of activities that improve health care quality currently exist. Likewise, Subsection H, Question 1 asks what policies, procedures or practices of insurers may be impacted by the MLR section of PPACA.

Our organizations believe that "activities that improve health care quality" should be defined broadly enough to include activities that: 1) relate directly to an individual patient's care; 2) provide tools to educate and inform patients about their current or future care and potential alternative cost savings; 3) prevent unnecessary and inappropriate care; and 4) ensure a minimum level of health care quality. All of these activities work to improve the quality of health care and/or to enhance access to quality care.

Health care consumers will best be served by a comprehensive and inclusive definition of clinical services and activities that improve health care quality, so that it:

- Adequately accounts for the wide spectrum and types of insurer activities that contribute to better health outcomes and care delivery efficiency; and
- Provides a level playing field among different types of insurers and products.

Many insurer activities are designed to ensure that consumers receive the best care at the best time—which leads to higher overall quality of health. Some of these activities improve quality through information sharing, while others work to reduce medical errors, improve provider services, or protect consumers from problematic services. Ultimately, all of these functions lead to better outcomes and lower premiums for consumers. These types of activities have been recognized as quality enhancing by many respected national organizations—such as the National Committee for Quality Assurance, the National Quality Forum and the Leapfrog Group, among others.

A reasonably broad definition of quality improvement activities will allow plans to advance new patient health and wellness programs that ultimately could "bend the cost curve" and help make coverage more affordable.

The NAIC's Statement of Statutory Accounting principles (SSAP) No. 85 also recognizes the importance of insurer activities to improve health coverage quality and control medical treatment costs. SSAP No. 85 provides a categorical list of "cost containment expenses." These six categories are:

i. Case management activities;
ii. Utilization review;
iii. Detection and prevention of payment for fraudulent requests for reimbursement;
iv. Network access fees to preferred provider organizations and other network-based health plans (including prescription drug networks), and allocated internal salaries and related costs associated with network development and/or provider contracting;
v. Consumer education solely relating to health improvement and relying on the direct involvement of health personnel (this would include smoking cessation and disease management programs, and other programs that involve hands on medical education); and
vi. Expenses for internal and external appeals processes.

We strongly urge HHS to build on SSAP No. 85 by using it as a basis for the statutory requirements Congress included in the PPACA as "activities that improve health care quality." We view this as only reasonable and sensible, considering that Congress put significant priority on such activities in other areas of the law:

- Section 1302 of the law requires essential health benefits include coverage of preventive and wellness services, chronic disease management, mental health and substance abuse disorders, including behavioral health treatment, and prescription drug benefits.
- Section 3201 provides bonuses as incentives to MA plans to improve quality based on programs that:
  - Use care management, identify gaps in care, and use nurses, nurse practitioners and physician assistants;
  - Focus on patient education and self-management, including managing chronic conditions, reducing declines in health status and fostering patient and provider coordination;
  - Provide support for systemic coordination through programs like medical homes, capitation arrangements and pay-for-performance programs;
  - Identify, address and ameliorate health disparities for at-risk populations;
  - Address patient safety;
  - Provide medication therapy management programs that go beyond the Part D requirements
  - Leverage health information technology for clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care.
- Title VI provides for expansive new fraud and abuse prevention and enforcement programs to help protect program integrity in government and private plans.
- Throughout the law, Congress required quality reporting, measurement and improvement, and new prevention and wellness initiatives, indicating the importance these efforts can have on improving health and lowering costs.

These patient services and anti-fraud and abuse initiatives included in the PPACA will be ineffective without administrative support, including case managers, clinical support staff, medication therapy management and drug adherence programs, nurse hotlines, and health information technology used to garner information to coordinate care. They also require significant effort to collect data, analyze what works well, implement programs derived from experience-based knowledge, and employing professional and proficient staff to manage these programs. Likewise, quality development, reporting and measurement conducted or aggregated by health plans will play a key role in improving quality, but will require significant resources to conduct.

These activities are not administrative in nature, but rather help to support direct patient care benefits through improved care management, support and activities to reduce health premiums. We encourage HHS to adopt a flexible and reasonably broad definition of these activities so plans are provided incentives to innovate based on improved knowledge of what works well to improve health care quality and that incorporates advances in medical science.

Informational Tools that Improve Health Care Quality

There are often many misconceptions about the costs insurance carriers incur related to tools, information and services that help to improve the quality of care. The types of information, service and tools that professional benefit specialists provide consumers are important and effective components of a better overall health care strategy, and their related costs should be included in any accounting of informational tool costs. Professional benefit specialists allow consumers to call and receive information on qualified medical professionals in their area, as well as the costs associated with each one. This information is valuable in helping individuals find and choose quality health care.

The information and assistance they provide aids in making determinations about accessing affordable care and educating consumers, allowing for better choices regarding their health care, which is directly linked to cost containment. Benefit specialists further the goals of price transparency, which also aids in keeping prices down, thereby giving insurance and health care access to more citizens. They also allow individuals to better evaluate their health care providers so that they can determine the best value for their health care dollars. Through the help of their agents or brokers, patients are able to access and evaluate cost and quality information as they make their health care decisions. This is a necessary component to both increase the quality of care through consumer behavior as well as "bend the cost curve" for that care. As quality and price become more transparent, they will be factored into patients' decisions on the selection of providers. This, in turn, will result in weeding out lower quality providers from our health care system, thereby increasing overall quality of care.

The Value and Inclusion of Ancillary Health Care Services

Our organizations urge the Department to consider and account for the significant positive impact on quality and health outcomes that disease and case management programs provide. We believe that these activities should appropriately be classified as costs related to clinical care. In a February 2010 issue paper developed on MLRs, the American Academy of Actuaries describes "case management, disease management, 24-hour nurse hotlines, and wellness programs" as more "akin to benefits than administrative expenses … [As such] it would be appropriate to include cost containment expenses as part of the value of benefits in the loss ratio calculation. Including these expenses in the loss ratio calculation encourages insurers to effectively manage the quality, efficiency, and cost of care for policyholders."

Specifically, wellness, disease and case management services improve and support the health of populations and are important components of population health management programs. These services complement and support a physician-guided health care delivery system and engage and support patients to mitigate illness and improve long-term health. Wellness, disease and case management services are built on a foundation of evidence-based clinical care and are measured by clinical impact on health status. These programs and services educate patients and promote self-management skills; provide coaching and nurse support; ensure safe transitions in care; improve medication adherence and management; coordinate care between providers and care settings; and enhance quality through evidence-based decision support, data analytics, disease registries and other technologies. They are primarily provided by licensed,

clinical health care practitioners in and across numerous health care delivery settings and offer benefits far beyond cost containment and claims adjustment activities.

We recommend the Department to support the classification of these services as either “medical expenses” or “quality improvement expenses” for the purpose of calculating a health plan’s MLR.

Transition Mechanisms for Existing Coverage and Obligations

We share the concerns previously expressed by the NAIC and American Academy of Actuaries, among others, that the new MLR requirements may have a potential disruptive impact on health insurance markets—especially individual and small group markets. We are particularly concerned about the impact of the MLR requirements prior to the effective dates of other insurance market reforms, due in large part to historical pricing practices employed in these markets.

Indeed, Congress prudently recognized the possibility of disruptive consumer and market ramifications in §2718(b)(1)(A)(ii), which explicitly provides that HHS may adjust the 80% MLR amount if the Secretary determines that its application may destabilize the individual market in such state.

Our organizations urge the Department to consider some transition mechanisms for existing coverage in order to protect against such destabilization before it might arise. Applying the 80% MLR requirement to existing individual and small group business that had originally been priced under different (lower) MLR expectations may require insurance carriers to experience significant losses on current blocks of business, with little to no ability to recover those losses. It is unlikely that some carriers can reduce the non-claims costs associated with existing business in order to reduce financial losses in seeking to comply with the MLR. Such a situation might lead some carriers currently active in the individual market to terminate the existing blocks of business and leave the market, in an effort to avoid those future losses and the potential solvency concerns associated with those future losses. If some carriers do exit the individual market, then those insurance plans’ former policyholders may find themselves unable to find new coverage in the individual market for a period of years, and would not be eligible for the new high risk pools created by the PPACA §1101 during the first six months after becoming uninsured.

Additionally, since the MLR for underwritten individual products typically increases with policy duration, a company whose individual book of business has a higher proportion of recently-sold business may find it more difficult to achieve an 80% annual MLR in the near future than a company having a more mature book of business (and a correspondingly higher MLR). As such, the application of uniform annual MLR requirements could have a disproportionate impact across companies, which could lead to additional volatility in premium and rate change levels in the individual market.

We strongly recommend that the Department consider transition mechanisms for insurance policies that might fall into these and related categories, and to take steps to ensure that consumers and covered populations are not adversely impacted through reduced access, services and competition.

Treatment of Pass-Through Expenses

We recognize that the intent of the MLR requirements is to reduce the cost of health care premiums for consumers and provide better value. However, we are concerned that in its application, the MLR provisions may have the unintended consequence of eliminating certain administrative cost savings in place today. Specifically, carriers today routinely collect funds that are passed-through to independent third-parties as an operational convenience to their members. For example, in the small business and individual market, health plans include commissions in their premiums, but pass 100% of these funds along to independent agents and brokers. This practice reduces the health insurance system’s overall operational costs, eliminating the need for businesses and consumers to prepare mail and track separate payments to their benefit specialists. It would be counterproductive for the MLR provisions to eliminate this cost-saving administrative convenience which carriers provide to their members.

We recommend that HHS remove fully-disclosed pass-through fees collected by carriers from the MLR calculation since 100% of these fees are transferred to independent third-parties. 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. In addition, when creating this exemption, we believe HHS should also ensure that the recipients of these pass-through fees are truly independent of the facilitating health plan and that 100% of the fees are transferred to the third party.

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 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.

Enhancement of Insurance Competition
In order to ensure that inappropriate methodologies for calculating MLRs do not drive insurers from and destabilize markets, we believe that the large group MLR should be at the aggregated legal entity level for the largest geographic area covered, and that a combined, state-based MLR should be used for the individual and small group market (at the aggregated legal entity level).

Aggregating groups in this manner will assure value to both employers and individuals. Blending large experience across the legal entity level is the most accurate way to assure reasonable distribution and best conforms to the accounting principle of matching costs to associated premiums.

If MLRs are set at the state level for the large group market, or calculated separately for the individual and small group markets, this could create significant market distortions and make it difficult for some insurers to offer coverage. For example, insurers whose business consists mostly of large groups rather than individuals and small groups would find it easier to meet MLR requirements. The result would be that insurers that could not attract significant amounts of large group business could find it difficult to satisfy the loss ratio requirement and exit the market, thereby reducing insurance market competition. This is especially a risk for individuals and small employers who already feel their choice is constrained in many states.

Administrative Efficiencies
Our organizations believe that the MLR calculations and related federal requirements should work within the parameters of established MLR processes already in place at the state level to reduce the administrative burden imposed by the regulatory changes. Specifically, we support:

- Use of calendar years for the basis of MLR calculations;
- Provision of rebates as premium credits to current customers; and
- Federal preemption of state MLR rules to avoid consumer confusion and inconsistency across markets.

Our experience is that states generally use calendar years and premium credits as the mechanism for MLR calculations and rebates. Each employer—even those enrolled in the same product line—has different plan years. Using a pure plan year calculation could result in thousands of MLR calculations per insurer in both the group and individual markets. In addition, cutting individual rebate checks to consumers would cost more in administration than would be returned to the consumer—resulting in higher premiums for all consumers and employers.

As a related issue to this latter point, consideration also should be given to a “de minimis” rule in the case of small rebate amounts, similar to what is used in Medicare supplement (0.5% of total premium), in which case rebates could be applied to future premiums. This would ensure that the cost of administering rebates is not greater than the rebates themselves.

Medical Loss Ratios in a Reformed Health System
We hasten to underscore that in and of itself, imposing minimum MLR requirements does not address many of the public policy concerns surrounding the health system. MLRs do not help contain medical care spending growth, ensure that health care services are appropriate and accurately billed, or address directly the quality and efficiency of health

care services. Therefore, while well-designed MLR requirements may be an appropriate component of the reforms enacted under the PPACA, such requirements should not be viewed as a panacea. Moreover, monitoring compliance with MLRs may create additional costs for insurers and regulators and, depending on how the requirement is designed, could create insurance market disruptions or distortions that could affect consumers. We urge the Department to take careful and deliberate consideration so as to mitigate such negative developments.

Professionally licensed and trained agents and brokers are committed to fostering quality and affordability without harming the insurance marketplace. The goal of health care reform was to provide affordable and quality health care to all Americans, and we must keep these goals in mind as we develop important MLR guidelines.

It is important to spend time clearly defining clinical services and administrative costs to allow insurance carriers to provide an array of services that will improve the health of Americans and provide them the health care they deserve, effectively and efficiently—including the important services provided by licensed health insurance agents, brokers and benefit consultants. Insurance carriers have an important responsibility to American consumers—to not simply pay claims, but to provide services and systems that help keep them healthy and help keep their insurance affordable.

It would be a disservice to patients and run counter to Congressional intent to mandate the inclusion of many new services as essential health benefits, and then define allowable expenditures for calculating the MLR in a way that makes it difficult or impossible to support these programs while maintaining an MLR that meets an inflexible threshold. In a post reform environment, limiting incentives for health plans to use dollars to better coordinate and manage care and to protect consumers' premiums through plan integrity efforts would be counterproductive and wasteful.

We sincerely appreciate this opportunity to provide information and comments to the development of MLRs, and also appreciate the Department's attention and consideration to this important area of regulation. We look forward to working with you as implementation of MLRs moves forward. If we can be of further assistance, please feel free to contact any of our respective organizations.

Sincerely,

The Council of Insurance Agents & Brokers (CIAB)
Independent Insurance Agents & Brokers of America (IIABA)
National Association of Health Underwriters (NAHU)
National Association of Insurance and Financial Advisors (NAIFA)