May 14, 2010

U.S. Department of Health & Human Services
200 Independence Avenue, SW., Room 445-G
Washington, D.C. 20201
http://www.regulations.gov
Attention: DHHS-2010-MLR

RE: Medical Loss Ratios; Request for Comments Regarding Section 2718 of the Public Health Service Act; 75 Federal Register 19297, April 14, 2010

AARP is pleased to respond to the Request for Comments on Medical Loss Ratios (MLRs) included in Sections 1001 and 10101 of the Patient Protection and Affordable Care Act (PPACA). AARP is a strong supporter of health reform and believes these provisions can promote more cost-effective care, improve pricing transparency, and make insurers more accountable for quality care.

Together with mandatory premium rebates for products that fail to meet the minimum standard, MLRs can serve as an incentive for health plans to reduce administrative overhead, thereby saving money for both consumers and taxpayers. Great caution is needed, however, in implementing the federal MLR standards to ensure intended outcomes. If key definitions, levels of aggregation, and other methodological aspects of calculating MLRs are not well constructed and applied, the resulting ratios could erode value for consumers by tolerating excessive spending on activities that contribute little or nothing to actual consumer benefit.

On the other hand, if insurers are prohibited from including all but the most restrictive definitions of medical and quality-related expenses, important quality improvement initiatives – many of which were sought by Congress in provisions throughout PPACA – could be discouraged.

We would like to underscore the importance of balancing the need to encourage quality improvement – including care coordination efforts – while preventing plans from simply reclassifying certain administrative expenses as “quality improvements.” We fully appreciate the challenge in striking the proper balance, and believe that development and enforcement of MLR policies will require refinement over time as we learn more about health plan activities that most effectively improve quality. We urge the Secretary to carefully monitor the effects of this provision.
A. Actual MLR Experience and Minimum MLR Standards

The Request for Comments (RFC) asks insurers and states to describe current MLRs and how they compare to PPACA standards (.85 for large group and .80 for individual and small group, with discretion given to the Secretary to modify for specified reasons). Information is also requested about factors that contribute to annual fluctuations; how the states vary requirements based on the plan size, type of plan and other factors; and factors that states consider in determining whether an MLR minimum would destabilize the individual market. As the data already provided to the National Association of Insurance Commissioners (NAIC) demonstrate, current state MLR standards vary significantly. It is noteworthy that there are significant differences between the PPACA MLR requirements and the NAIC guidelines.

Although many states require insurers to report MLRs to their insurance departments, few disseminate the information to the public and fewer still require rebates for policies that do not meet minimum standards. According to data supplied to the NAIC by America’s Health Insurance Plans, only six states require carriers to issue a rebate to enrollees for failure to comply with MLR requirements. MLR definitions also widely vary and few if any states appear to have adopted standards that explicitly include quality improvement as a category of expenditures that is treated distinctly from either clinical or administrative expenses (although the NAIC guidelines identify specific “cost containment” functions, some of which may be considered quality-related activities). We therefore urge you to look to state law experience to help determine what works best to promote consumers’ interests, but not as precedent for national standards.

B. Uniform Definitions and Calculation Methodologies

Comments have been requested on how best to measure MLRs. Specifically, the RFC seeks responses to questions about current definitions and methodologies used by states and other entities in calculating MLR-related statistics, the assumptions and methodologies used for current MLR standards and for allocating administrative expenditures, and the pros and cons of various methods. In addition, the RFC asks about existing definitions for identifying and defining activities that improve health care quality and the pros and cons associated with including various kinds of activities on the list of quality improvement activities.

As noted, AARP believes that successful implementation of the MLR standards depends on striking a careful balance in defining activities that are “clinical” or contribute to “quality improvement” and those that are undertaken solely for administrative, overhead and cost containment purposes. We recognize that achieving that balance presents a significant challenge and that some activities may be arguably included in either category depending on how they are actually carried out by a particular insurer.
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Of critical importance is a clear and specific definition of “improving quality.” In addition, allocation of expenses to “quality improvement” must be transparent, with the burden of proof on the insurer to justify such allocation. We believe “improving quality” should include activities to ensure that care is effective, safe, patient-centered, coordinated, equitable, and efficient. We recognize that including quality expenses in the numerator of the MLR, especially in conjunction with the requirement to issue rebates for failing to meet the MLR standard, will create a strong incentive for insurers to classify as many expenses as possible in this category. This is a serious concern, especially given the cost pressure on insurers operating under insurance market reforms. If there are imprecise definitions of quality-related expenses that can go into the MLR numerator that are not easily audited for compliance, the result could be reduced spending on items and practices that are of value to and benefit consumers.

PPACA contains numerous provisions that encourage or require collection, aggregation and public reporting of quality metrics, care coordination, improved delivery of services for people with chronic conditions, wellness, prevention, and health promotion, as well as acceleration of adoption of health information technology (IT), such as electronic medical records. Congress identified these types of initiatives as having the potential to improve care and promote greater efficiency in health care delivery. In addition, spending to achieve high-level accreditation or recognition in programs that designate high performance in specific clinical areas may also qualify for inclusion as quality improvement activities. The Secretary should carefully consider whether these types of activities merit inclusion in the MLR numerator.

With certain activities, such as use of health IT, it can be more difficult to draw a bright line between quality improvement and administrative expenditures. This underscores the importance of transparency in reporting information to regulators and the public. The components of the numerator in the MLR should be auditable and the Secretary should develop an audit strategy that will ensure appropriate oversight and review.

C. Level of Aggregation

As noted in the RFC, insurance-related data may be aggregated at the policy form level, by plan type, by line of business, by company, or by state, depending on the context in which it is being presented. Comments are requested on the pros and cons associated with using various possible level(s) of aggregation in submitting medical loss ratio-related statistics to the Secretary, publicly reporting this information, determining if rebates are owed, and paying out rebates. The level of aggregation is likely to prove critical to the way in which MLRs are calculated and the extent to which insurers are required to provide for premium rebates. If an insurer averaged its MLR across its individual and small group books of business, for example, greater pressures might be brought to bear on its small group business where MLRs are generally higher.
Conversely, such averaging across individual and small group lines of business might improve the value of individual coverage but may have adverse effects on small group coverage. In addition, it is important to calculate MLRs so that consumers can readily compare MLRs for different coverage options. We therefore urge you to require insurers to calculate MLRs for each line of business.

D. Data Submission and Public Reporting.

Comments are requested on state reporting requirements related to MLR statistics and the timing of these statistics. Comments also are requested about the availability of the MLR data to the public. Also asked is whether there are industry standards or best practices related to the submission, interpretation and communication of MLR statistics.

We reiterate the importance of maximum transparency with respect to MLR reporting. Information should be provided in a timely manner and in standardized language that the average consumer can readily understand in order to facilitate informed choices among competing insurance options.

E. Rebates

PPACA requires issuers whose coverage does not meet the applicable minimum MLR standards for a given plan year to provide rebates to enrollees on a pro rata or proportional basis. The manner in which the rebate is calculated is specified in the statute. Comments are requested on the current state practices and other entities related to rebates for the different insurance markets; the timing related to the determination of whether rebates are required; how the recipients of the rebates are determined; and the different approaches used to notify enrollees if rebates are owed as well as how they are paid.

AARP notes that while the law requires an “annual rebate,” it does not specify when such a rebate is due or to whom the rebate is to be provided. We appreciate that different issues and administrative challenges arise with respect to the timing and distribution of rebates depending on whether rebates are paid to current enrollees or enrollees for the plan year in which the plan failed to reach the MLR. AARP believes the fairest way to administer the rebate provision is to provide rebates to all policyholders enrolled in the plan during the applicable time period, whether or not they are currently enrolled. Rebates for any individuals who cannot be located should be applied toward reduction of premiums for all policyholders in the subsequent plan year.
G. Enforcement

PPACA requires the Secretary to publish regulations for enforcing this provision and specifies that the Secretary may provide for appropriate penalties.

AARP believes that penalties should be sufficient to discourage noncompliance on the part of issuers, and should specifically address any failure to comply with the reporting requirements. In addition, we support enforcement procedures that allow for adequate due process and transparency. Insurers should have fair recourse to appeal a determination of noncompliance but the procedures for the appeal should not become impediments to timely resolution.

Thank you again for the opportunity to comment on this important matter. If you have questions, please contact Paul Cotton on our Federal Affairs staff at (202) 434-3770.

Sincerely,

David Certner
Legislative Counsel & Legislative Policy Director
Government Relations & Advocacy

CC: National Association of Insurance Commissioners
BWebb@naic.org  Tvaughan@NAIC.org