August 4, 2010

Ms. Jane L. Cline
President, National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Dear Ms. Kline:

As a consumer organization with millions of members throughout the United States and the territories, AARP was a strong and forceful advocate for health reform legislation. We continue to have a keen interest in seeing that implementation of this legislation meets the intent of the law—to provide access to affordable, high quality health care to all Americans. In that connection, we are writing concerning the above referenced section of the law that applies to medical loss ratios (MLR).

The Accountable Care Act (ACA) requires health plans to provide a “clear accounting for costs”, including “the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums.” Health plans must report the percentage of total premium revenue spent on (1) reimbursement for clinical services provided to enrollees; (2) activities that improve quality; and (3) all other non-claims costs.

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 improve care. On the other hand, if insurers are too tightly restricted in what can be included under the definitions of medical and quality-related expenses, important quality improvement initiatives – many of which were sought by Congress in provisions throughout ACA– could be discouraged. Below are illustrations of activities we think contribute to quality improvement– and which therefore should be recognized as medical expenses in the MLR calculation– and those that do not.

Section 2717 (a)(1)(A) of the ACA includes examples of activities that improve quality of care. These are: quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical home model for treatment or services. These activities provide a useful sense of what Congress intended as legitimate quality activities. They should be recognized as legitimate quality activities when health plans invest in them directly—for example, through health plan programs reporting on the performance quality of participating providers—or when health plans require providers to do them—for example, by designing coverage and reimbursement structures in such a way that providers have the incentive to create and participate in performance measurement and reporting programs.
In addition, AARP believes several activities that will enable or facilitate implementation of the activities delineated in the legislation should also be recognized. Examples include, expenses associated with: accreditation; activities that improve patient safety and reduce medical errors, such as initiatives to prevent complications or infections and reconciliation of medications; activities to prevent or reduce hospital readmissions; activities to enhance electronic information sharing between and among providers via health information technology; health information technology that enables patients to have electronic access to their medical records and that provides clinical decision support to clinicians.

With respect to “transparency,” we support classification as “quality improvement expenses” of the costs health plans incur related to reporting to their enrollees or to the public providers’ performance on standardized, nationally endorsed measures, including the costs associated with fielding patient experience surveys. Such reporting can motivate and guide provider quality improvement and can help consumers choose high-quality providers. Therefore, costs for data collection, auditing and data transmission to ensure that data are properly aggregated and validated are legitimate quality expenses.

AARP does not support inclusion of the following activities or expenses: fraud and abuse expenses; utilization review activities that are conducted merely for cost containment purposes (e.g., retrospective and concurrent reviews, medical authorization programs); costs associated with establishing or maintaining claims adjudication systems or technology costs associated primarily with paying claims or complying with administrative requirements that are HIPAA-related; costs associated with managing a provider network, including provider contracting; provider credentialing; costs of conversion to ICD-10; costs associated with internal and external reviews of complaints and appeals; and costs associated with health and wellness incentive programs that are not evidence-based. We note that organizations such as the National Committee for Quality Assurance have programs that certify organizations and programs that meet specified standards in wellness and health promotion, disease management, and other areas that could be useful in determining whether an insurer’s activities in these areas are designed to improve quality.

We stress that AARP does not support “creative accounting” or other practices that would designate routine business activities as quality-related. We want to underscore the importance of balancing the need to encourage quality improvement 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.

Unfortunately, the evidence and knowledge base for quality improvement is inadequate. Until this evidence base is enlarged, there are instances where well-founded, widely-accepted, expert opinion must be a sufficient basis for health plans to implement activities intended to improve quality and, in turn, have them classified as “quality improvement activities.” AARP believes that activities should not be classified as “quality improvement activities” unless there is a sound basis, either from experimental research or from widely-supported independent expert opinion, for believing that such activities can be expected to improve health care quality and increase the likelihood of desired health outcomes. Qualified quality improvement expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by
recognized professional medical associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations.

In conclusion, it is noteworthy that section 2718 is titled “Bringing Down the Cost of Health Care Coverage” while subsection (b) addresses “Ensuring That Consumers Receive Value For Their Premium Payments.” Both headings express clear and compelling objectives that are of critical importance to our members. It is essential for consumers to realize value for their premium dollars spent; value factors cost and quality into the equation, whereas premium reduction simply considers price. Although the MLR statistic may be useful to incent administrative efficiency, reduce marketing costs, prevent excessive profits, and promote pricing transparency, it may not be necessarily the best statistic to assess the value of quality improvement initiatives. Therefore, we must proceed carefully. Reliance on the MLR as a determinant of high or low quality is contentious. One leading health economist has observed that, “High ratios can be achieved either through a large numerator (high medical expenditures) or through a small denominator (low insurance premiums). The medical loss ratio, as a ratio of the two, can be measuring the impact of medical market competition on expenditures or of insurance market competition on premiums.”

It was further pointed out that neither premiums nor expenditures by themselves indicate quality care. Careful monitoring of the effects of implementing Section 2718 will be essential and we urge you to acknowledge in your recommendations to the Department of Health and Human Services (HHS) the need to review these effects regularly to ensure there are no unintended consequences.

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

Sincerely,

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

cc: Steven Larsen, U.S. Department of Health and Human Services
Commissioners, National Association of Insurance Commissioners

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1 James C. Robinson, “Use And Abuse of the Medical Loss Ratio to Measure Health Plan Performance,” Health Affairs, Volume 16, Number 4, pp.176-187.