



STANDARDS FOR MEDICAL LOSS RATIOS SHOULD BENEFIT THE PUBLIC

August 11, 2010

The Honorable Kathleen Sebelius
Secretary, Department of Health and Human Services
Hubert Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Attn: Brian Webb, NAIC, bwebb@naic.org and cavila@naic.org

Re: Medical Loss Ratio (MLR) "Blanks" proposal by the Financial Condition (E) Committee, NAIC

Dear Secretary Sebelius:

The Affordable Care Act (ACA) empowers the Secretary to define the Medical Loss Ratio (MLR) in a way that benefits the public. We urge you to implement regulations that will help to set affordable premiums and bring down health care costs, by providing incentives to the health insurance industry to operate efficiently and to negotiate assertively with health care providers, rather than simply passing on cost increases to consumers.

We are concerned that the standards most recently proposed for review by the National Association of Insurance Commissioners (NAIC) include an edit that would allow the insurance industry to count marketing campaigns performed in conjunction with state and local public health departments as medical expenses. This reference appears in the Medical Loss Ratio (MLR) "Blanks" proposal by the Financial Condition (E) Committee of the NAIC dated June 29, 2010. **We consider this an avenue to inflate charges unduly, and ask you not to accept this proposal.**

The NAIC is charged with developing proposed regulations, and reporting its proposals to your office. We offer these comments in the hope that the NAIC will more equitably balance the interests of the public and of the insurance industry, and we further ask that you, Madame Secretary, make an independent assessment of their recommendations.

The EQUAL Health Network brings together partners from public health, women's health, the faith community, seniors and the public on a national basis to advocate for Equitable, Quality,

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Universal, Affordable health care. We have been active supporters of the ACA, and submitted formal comments on the MLR to HHS on May 14, 2010.

We outline here a brief summary of the ACA provisions regarding the Medical Loss Ratio, the present proposals under consideration by the NAIC, and recommendations for the HHS' regulations. The agency has established a popular track record of responding to and reining in insurance industry abuses. We appreciate your personal commitment to protecting and advancing the public's interest in access to affordable health care.

The Law: ACA calls for Medical Loss Ratio That Controls Costs, Provides Value

The stated objectives of Section 2718 of the Patient Protection and Affordable Care Act (PPACA) are "bringing down the cost of health care coverage" and "ensuring that consumers receive value for their premium payments." In pursuit of these aims, the law requires health insurance companies to spend at least 85% of premiums on patient care, a figure known as the "medical loss ratio" or MLR, and only 15% on administration and profit, in the large group market. In the small group market, the figures are 80% MLR and 20% for administration and profit. Companies must also report the calculations for their MLR. This rule is in effect until 2014, when health exchanges are set to begin. It applies to all health insurance plans, including grandfathered plans.

The aims of Sec. 2718 - low cost care that offers value to consumers – conflict with the financial imperatives of the health insurance industry, to maximize profits and returns to shareholders, as well as administration, including executive compensation. Proposals by the insurance industry call for calculating the MLR in a way that will frustrate the aims of the law. The MLR is a ratio, with all medical claims (in the numerator), divided by total premiums (in the denominator). A high MLR means that the insurance company is spending a relatively higher share of premium income on its members' medical care and less for administration and profit. A low MLR means that the insurance company is returning less in medical care benefits to its members while retaining more for executives and shareholders; this can also signal a solid opportunity for investors.

To fairly achieve an 85% MLR, a company would have to show that the amount spent on medical claims (in the numerator) is high relative to premiums. But companies can frustrate the intent of the law by defining medical claims to include other expenses, including expenses typically considered part of administration.

Defining "Activities That Improve Health Care Quality"

Section 2718 of the ACA defines clinical services (2718 (a)(1)) **and activities that improve health care quality (2718 (a) (2))** as part of the numerator of the MLR, while non-claims costs (2718(a)(3)) reside on the administration side.

“SEC. 2718 (42 U.S.C. 300gg–18) BRINGING DOWN THE COST OF HEALTH

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CARE COVERAGE.

“(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

“(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 Federal and State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

“(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

This allows companies to count, among the 80 - 85% spent on medical care, "activities that improve health care quality" as a component of the MLR.

The insurance industry’s proposals ask the NAIC to define the MLR to its advantage, by counting marketing programs, including those with public health themes, as medical expenses, rather than the administrative expenses they clearly are. This is an open invitation to the industry to “game” the system.

The insurance industry has already stated its intention to game the system by raising premiums to make up for any constraints imposed by the new law,² and has begun to game the MLR rules for its own gain. The Senate Commerce Committee has documented that, "At least one company, WellPoint, has already ‘reclassified’ more than half a billion dollars of administrative expenses as medical expenses, and a leading industry analyst recently released a report explaining how the new law gives for-profit insurers a powerful new incentive to ‘MLR shift’ their previously identified administrative expenses."³

Part of the justification for unfounded charges is the industry's incursion into activities such as alliances with disease management programs, which it attempts to characterize as a clinical benefit rather than administration and marketing.

NAIC committees have been working largely outside of the public's view to draft standards. The committees' drafts have been edited by sources not publicly identified to date. The draft proposal of June 29, 2010, includes the unattributed edits, shown below in **boldface and underline**, for items that may be considered medical expenses:

Column 4 – Wellness & Health Promotion Activities

Expenses for programs that provide wellness and health promotion activity as defined above (e.g., face-to-face, telephonic or web-based interactions or other forms of communication), including:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
- **Public health marketing campaigns that are performed in conjunction with state or local health departments;**
- Actual rewards/incentives/bonuses/reductions in copays, etc. (not administration of these programs) **that are not already reflected in premiums or claims** should be allowed as QI with the following restrictions:
 - Only allowed for small and large employer groups, not individual business; and the expense amount is limited to **the same percentage as the** HIPAA incentive amount (currently 30%);

The ACA standard for including expenditures for non-clinical care as a medical expense (that is, in the numerator) is that it must “improve health care quality.” It is important to note this standard carefully. It does not legitimate including activities that improve the health of the public. This is the province of public health agencies. Contributions to public health endeavors are always welcome, particularly in the current climate of scarce resources. Insurance companies may consider collaborations with public health departments to be advantageous, in that successful programs will in the long run reduce medical claims. However there are three important issues to consider carefully in this regard:

1. Insurance companies and other for-profit businesses typically contribute to the work of public health departments by paying taxes. The ACA exempts certain insurance company taxes from inclusion in calculating the MLR; that is, taxes are subtracted from the denominator, making the companies' income appear to be lower than it actually is. In this way, insurance companies already benefit from their contributions to public health departments, via taxes.
2. Any activity that qualifies for classification as a medical expense must meet the test of improving health care quality. This means that there must be evidence of measurable, demonstrable improvement. Marketing campaigns do not meet this standard.
3. While we do not support incentives to insurance companies to engage in areas beyond their function and expertise, we note that there are legitimate standards for community

public health education programs, most notably those promulgated by the Community Guide, which is affiliated with HHS. We commend this body to the attention of the NAIC.

Our own initial survey of health departments, and of insurance industry reports, found little evidence of current collaborations between insurance companies and public health departments. There are a few reports of insurance companies' co-sponsorship of visible public health events. While this is certainly a legitimate optional activity, it does not justify skewing the MLR in ways that would raise premiums, or requiring the additional administrative effort to determine whether or not it is in itself an administrative or medical expense.

The NAIC and HHS should discourage efforts by insurance companies to create and benefit from insubstantial programs that masquerade as clinical treatments. These programs should be properly counted as the administrative expenses that they are. Otherwise, a proliferation of such programs, if regarded as clinical care, would have the exact opposite of the intended effect of the measure: it would cause health care expenditures to balloon, and dilute value for consumers.

The MLR Should Be Defined Narrowly

Regulatory standards defining costs of care and of quality improvement are important. An array of health insurers that are highly rated for quality regularly attain medical loss ratios of around 90 percent or more. (For example, major non-profit Massachusetts insurers often achieve and exceed that threshold; in recent years, Fallon, Harvard Pilgrim, and Tufts HMO have annually spent 87-91 percent of their premiums on care.) Many patient advocates supported requiring at least a minimum medical loss ratio of 90 percent, and an 85 percent standard is clearly easily attainable by insurers with large memberships.

The ACA standard applies only to insurers' premium revenues. Yet patients and payors should be equally concerned about how an insurer uses income from its investment of the sums it extracted from previous years' patient premiums. A more appropriate standard would measure the share of insurers' total revenues devoted to care, as some analysts have urged.⁴

Given these factors, it is vital that the "medical" and "quality improvement" portion of insurance expenditures be defined strictly, and that standardized reporting requirements be detailed to prevent miscategorization of administrative expenses. It is also vital that rate review and other pressures be strong enough to prevent insurers from simply raising premiums in order to offset the limit on their administration/profit share.

Continuous Monitoring, and Involvement of Patients and Advocates

It will be important to create an ongoing process to set and review the initial regulations which are required to begin in September, 2010. Public comment on this system's achievements and

limitations will provide important assessments of the system's success, and offer the groundwork for constructive and equitable adjustments to the rules.

Sincerely,

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Robert Mason, Policy Fellow, EQUAL Health Network

cc: Sen. Jay Rockefeller
Jay Angoff, HHS

¹ A review of states' rules on MLR, compiled by the National Association of Insurance Commissioners (NAIC) and published by America's Health Insurance Plans (AHIP), shows that most states do not use this definition, and define administrative expenses straightforwardly. State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations (as of April 15, 2010). AHIP.

² Judy Dugan, Jerry Flanagan, Carmen Balber. Comments from Consumer Watchdog to NAIC on medical loss ratio rulemaking per Section 2718 of PPACA, May 10, 2010.

³ Committee On Commerce, Science, And Transportation, Office Of Oversight And Investigations, Majority Staff . Implementing Health Insurance Reform: New Medical Loss Ratio Information For Policymakers And

Consumers. Staff Report for Chairman Rockefeller April 15, 2010.

http://commerce.senate.gov/public/?a=Files.Serve&File_id=d20644bc-6ed2-4d5a-8062-138025b998ef

⁴ Alan Sager and Deborah Socolar, "A Better Deal for Our Health Care Dollars: Testimony to the Joint Committee on

Insurance, Massachusetts General Court, on H. 1208, An Act to Promote the Efficient Use of Health Care Revenues," Health Reform Program, Boston University School of Public Health, April 2, 2001,

<http://dcc2.bumc.bu.edu/hs/sager/A%20Better%20Deal%20%20Apr%2001.pdf>;

Robert Padgug, Rekindling Reform, testimony at state health reform hearings, 30 October 2007, partnership4coverage.ny.gov/hearings/2007-10-30/testimony/docs/robert_padgug_-_rekindling_reform.pdf.