

**America's Health
Insurance Plans**

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org



January 31, 2011

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-9998-IFC
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Interim Final Rule – Medical Loss Ratio Requirements (OCIIO-9998-IFC)
Submitted via www.regulations.gov

Dear Sir or Madam:

I am writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the interim final rule ("IFR") relating to the *Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule* published in the *Federal Register* on December 1, 2010. The IFR implements Section 2718 of the Public Health Service Act, as enacted in the Patient Protection and Affordable Care Act (PPACA), which was signed into law March 23, 2010.¹

AHIP is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and have demonstrated a strong commitment to participation in public programs.

We appreciate the opportunity to comment on Medical Loss Ratio (MLR) requirements of the IFR. Since the IFR was published on December 1, 2010, and has an effective date of January 1, 2011, we urge that the Department act as quickly as possible to take additional regulatory action to address the concerns and comments raised as part of the regulatory process.

This letter highlights our general concerns about the IFR while the Attachment sets out more specific concerns related to the *Federal Register* notice and the regulatory text.

While we focus our comments on the MLR regulation, we are also mindful of the substantial concerns policy experts have voiced for years about the unintended consequences of using MLRs

¹ Pub. L. No. 111-148, as amended by Pub. L. No. 111-152.

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for purposes other than monitoring health plan solvency – the purpose for which these measures were originally meant to serve.

Key Concerns Related to Disruption for Consumers, Impact on Quality Investments, and Increased Administrative Costs

Recognizing that the Department of Health and Human Services (HHS) has an obligation to implement the MLR provision, our comments focus on concerns relating to how the specific implementation path established in the IFR should be changed in order to:

- Minimize disruption in the marketplace for consumers and promote competition;
- Avoid raising administrative costs throughout the health care system;
- Avoid crowding out innovations and investments in health care quality and limiting consumer choices; and
- Provide for an adequate “credibility adjustment” to address volatility and avoid solvency issues caused by statistical “false positives.”

Overall, our comments focus on alternative approaches to mitigate potential coverage disruptions and other unintended consequences, and that avoid disturbing or impairing continued private sector efforts that are helping lead the nation toward a 21st century health care system.

It is important to keep in mind that health plan administrative costs have been declining as a percentage of total national health expenditures (NHE) and private health insurance (PHI) premiums for seven years in a row. Private health insurance administrative costs now constitute 3.5 percent of total NHE, reflecting market incentives that encourage efficiency in health care administrative cost spending. This helps demonstrate why by focusing only on health plans, the MLR risks drawing attention and energy away from efforts to address true cost drivers in the health care system such as the continued growth in underlying medical costs.

Meanwhile, new studies and research continue to demonstrate that health plan quality programs and innovations in payment and delivery system reform are helping to ensure greater coordination and less fragmentation in the health care system. For example, a recent article concluded that health plans improve the quality of care through tools, such as disease management, provider education efforts, patient education efforts, the development of reminder systems, and the use of financial incentives and other activities.²

² Laurence C. Baker and David S.P. Hopkins, International Journal for Quality in Health Care, “The Contribution of Health Plans and Provider Organizations to Variations in Measured Plan Quality,” (March 18, 2010).

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These tools, as well as other health plan activities, not only produce better clinical outcomes, but also result in significant cost savings. Many health plans, for example, are seeking to reduce preventable hospital admissions, readmissions, and emergency room use through a wide range of patient-centered initiatives that focus on rebuilding primary care efforts, engaging patients, and recognizing the important role of pharmacists. A recent AHIP survey indicates that these programs are reducing costs, improving quality, and positively impacting patient satisfaction.³

I. Minimize Marketplace Disruption For Consumers and Promote Competition: The Essential Need for an Effective Transition to a 2014 Post-Reform Market

Two issues are paramount to our concerns over the potential for marketplace disruption and the impairment of competition: (1) the need for an effective transition to the 2014 reforms for all markets; and (2) modification or supplementation of the credibility adjustment to more adequately address random year-to-year statistical volatility in MLR measures.

Need for a Transition – Differences Between Current Market and MLR Rules

We urge HHS to place a high priority on minimizing disruption and preserving consumer choices in the marketplace during the 2011-2014 period leading up to the implementation of PPACA's major insurance market reforms. PPACA established the new minimum loss ratio standards of 80 percent (individual and small group markets) and 85 percent (large group market). Recognizing that the standards for loss ratios were significantly lower or did not exist in some states prior to the PPACA, we urge HHS to adopt a predictable and effective transition plan designed to reach all three market segments.

From now until 2014, it is vitally important to minimize disruption in the pre-reform marketplace. Four-fifths of the individual market will remain medically underwritten, guided by the rules and regulations in each state. A transition policy is needed to move from the current system to the new system that will be created in 2014 and to allow individuals and those receiving coverage through employer group health plans to maintain their coverage. In addition, a smooth transition and preservation of the marketplace leading up to 2014 will provide consumers with continued choices and stability until the Exchanges are operational and the rest of the market reforms become effective. Until that time, consumers in the individual and small group markets will rely on brokers to review their insurance options and consider which ones best suit their needs. Thereafter, brokers will continue to have an important role to play, but will

³ AHIP Center for Policy and Research, "Innovations in Reducing Preventable Hospital Admissions, Readmissions, and Emergency Room Use: An Update on Health Plan Initiatives to Address National Health Care Priorities" (June 2010) accessed at: <http://www.ahipresearch.org/pdfs/innovations2010.pdf>

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operate in the context of new systems for making coverage available to consumers and employers.

Similarly, the large group market typically has not been subject to loss ratio requirements. This reflects the sophistication of large group purchasers and the custom element of benefit packages and associated cost and quality programs often demanded by large group purchasers. For many carriers, large group pricing is not developed on a state-by-state basis, such that the imposition of a MLR counted state-by-state will constitute a major change to existing business practices. This will cause some large groups to incur significant new administrative costs they do not incur today, and will require a substantial period of adjustment to promote stability.

Policies for 2011 Were Filed Well Before Publication of the MLR Regulation and Reflect Solvency Assumptions & State Regulatory Requirements in Place At That Time

Supporting the case for an effective transition, rates that are in effect in today's 2011 market were filed and approved many months before the components of the MLR standards were known. This regulation was published on December 1 2010, with an effective date of January 1, 2011. Rates were filed with states in some instances, in February and March of 2010, even before the legislation itself was signed into law. Failing to include some form of transition, or some safe harbor for health plans whose rates were appropriately based on their states' existing MLR requirements, damages the solvency assumptions those health plans – and their state regulators – made at the time the rates were developed and approved. HHS should provide specific transition guidance leading to 2014 to ensure that these solvency assumptions are not ignored.

Structural Issues Driving Need for Transition Concept

To be effective, a transition should recognize structural issues associated with each of the individual, small group, and large group markets now and in 2014. Key among these are issues concerning current market cost structures and operating models, which when understood make the case and need for transition clear.

In particular, health plans have developed cost structures and operating models to meet the needs of consumers and employers across different insurance markets. These structures also reflect existing regulatory requirements and market rules that remain substantially unchanged for most types of coverage prior to 2014.

Below is a chart showing why the pre-2014 market is structurally different from the 2014+ market:

2011-2013 Marketplace	2014+ Market
<p><i>Volatility in MLR calculation</i></p> <ul style="list-style-type: none"> • Annual, state specific MLR calculations, creating significant issues in volatility in MLRs across states year by year • No risk adjustment 	<p><i>Mechanisms introduced to provide less volatility in MLR calculation</i></p> <ul style="list-style-type: none"> • 3-year averaging to smooth the volatility of results • Introduction of risk adjustment, and transitional reinsurance and risk corridors
<p><i>Higher costs relating to underwritten individual markets in most states</i></p> <ul style="list-style-type: none"> • “Durational” issues meaning MLRs rise with the passage of time • Administrative costs relating to underwriting 	<p><i>New rating rule and guarantee issue reduce administrative costs</i></p> <ul style="list-style-type: none"> • Durational issues minimized because market is no longer underwritten • No underwriting costs
<p><i>Distribution channel through agents and brokers</i></p> <ul style="list-style-type: none"> • Principal distribution channel for individual and small group coverage • Source of human resources type functions for individuals and employer groups 	<p><i>Exchanges established and functional</i></p> <ul style="list-style-type: none"> • Alternative distribution mechanism • Possible assistance of brokers, ombudsman, and others with human resources type functions
<p><i>Administrative spending higher as a percentage of premium</i></p> <ul style="list-style-type: none"> • Benefit packages designed for affordability, especially in individual and small group market, have a higher percentage of overall premium expended on administrative costs. 	<p><i>Administrative spending lower as a percentage of premium</i></p> <ul style="list-style-type: none"> • New essential benefit packages and actuarial value requirements will result in lower percentage of overall premium being expended on administrative costs

The fact that the MLR rules are in effect prior to the creation of the new rules and infrastructure planned for the 2014 and beyond environment creates a mismatch giving rise to the need for an effective transition.

Recognizing these facts, numerous experts, including the American Academy of Actuaries (AAA), have urged that a transition plan be included as part of MLR implementation. The National Association of Insurance Commissioners (NAIC) similarly urged for a transition

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although they did not include one in their regulation, based on the perceived scope of authority and mandate for making recommendations.

While the IFR proposes the potential for a transition for the individual market, it makes no such proposal for the small group or large group markets. In addition, even with respect to the individual market, the approach laid out in the IFR is unnecessarily burdensome requiring very detailed data submissions and speculative calculations, and provides little of the deference requested by state regulators in their October 13, 2010 recommendations for transition.⁴ Moreover, despite the fact that the MLR became effective January 1 2011, the application process outlined in the IFR provides little in the way of certainty with respect to timing as exemplified by a provision that keeps the “clock” on review from even starting until after HHS determines in its discretion that the application is “complete.”

Essential Elements for an Effective Transition

The policy goal should be to create a transition that works. Three elements in this regard are essential:

1. Recognize that the basic structure of the market is unchanged in 2011, 2012, and 2013 as illustrated above.
2. Use an application process that minimizes the burden on states and encourages rather than discourages them to apply for a transition in each of the individual, small group, and large group market segments as necessary.
3. Provide adequate flexibility to ensure that transition plans can address key fundamental differences between the current market and the reformed market, especially as they relate to cost structure and volatility.

In addition, an effective transition would also take the form of a bridge, at least allowing states adequate time to evaluate and put together an appropriate transition plan that meets their citizens' needs. In this regard, the need for a bridge is present across all market segments, including in the large group market where time is needed to restructure existing contractual arrangements with employers. As an example from the large group segment, one complexity that arises and requires time to address involves multiple contracts between a carrier and a single employer, but where the arrangements are structured to ensure that the employer is treated consistently across its enterprise, even where the employer operates in multiple states.

⁴ See NAIC Letter to Secretary Sebelius (October 13, 2010), “We urge HHS to give deference to the analysis and recommendations of state regulators when determining how the new requirements will be phased-in.”

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A bridge would help guard against disrupting or impairing these existing contractual obligations and related arrangements, reducing the risk that MLR implementation becomes a source of inefficiency and concern in the workplace, and could provide time for a state-based application process to be put into place and made effective.

II. Avoiding Increases in Administrative Costs Across the System

We are concerned that the IFR reflects an approach to regulation that will have the unintended consequence of increasing administrative costs across the health care system rather than decreasing them. This runs counter to the spirit and words of the recent Executive Order on regulatory streamlining which recognizes the fact that “regulations have costs.”⁵

As examples of our concerns, we highlight three areas where the IFR overreaches, imposing requirements not required by statute or the NAIC, and lacks any significant consideration of less complex alternatives.

These examples illustrate how the IFR will require the creation of whole new information technology (IT) systems, contracts, and administrative compliance centers to address and manage the complexity of the proposed requirements, and the unprecedented involvement of government into the records of private entities, including entities other than health plans that are not, by Congressional design, even subject to the MLR regulation.

Treatment of Rebates Paid to Employers on Behalf of Their Employees

The IFR holds health plans responsible for multiple payments based on the actions of employers they do not control, while at the same time recognizing that health plans do not have the information to provide specific rebates to all individual enrollees, especially those who are members of employer group health plans. Our concern is that the unintended consequence of this policy will be a significant increase in administrative costs tied to whole new audit processes and procedures designed to assess compliance, which ultimately will lead to higher costs for consumers and employers.

An alternative to the approach outlined in the IFR would ensure that, health plans can rely upon the appropriate actions of the employer/policyholder. To accomplish this, the regulation should include a specific safe harbor permitting health plans to rely upon the accuracy of their employer-clients’ representations.

⁵ Executive Order 13563, “Improving Regulation and Regulatory Review,” (January 18, 2011).

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Artificial Deconstruction of Payments to Vendors and Providers and the Risk of Increased Health System Costs

The IFR contains language and examples suggesting that when a health plan pays a vendor or provider on a fee for service or medical/quality capitation claim, those parties may be required to itemize and deconstruct payments they receive in order to break out any administrative component embedded within the claim.

By injecting this burdensome and wasteful administrative requirement, this provision risks creating an extremely difficult system to administer that will significantly increase costs for the nation's health delivery system without adding any value to consumers. In *every* claim for health care, overhead must be built into the fee. Even non-profit and government-run providers must include these amounts in order for the entity to continue functioning efficiently and effectively. It would be especially burdensome if this provision were to be interpreted as requiring that every claim for services or contract for payment be accompanied by a detailed breakdown of all intermediary or provider's costs built into the claim.

Moreover, by potentially discouraging a range of models that rely on more aggregated payments, this provision seems at odds with the wide range of public policy efforts designed to encourage a movement away from fee-for-service payments toward a more value based payment system. In addition, it may also discourage competition by unintentionally impeding certain alternative network models.

If implemented without attention to the concerns articulated above, it is difficult to see how this provision will advance any positive goal. Moreover, it will again have the effect of increasing, rather than reducing, administrative costs.

Unprecedented Demands of Access to Premises and Records of Entities Not Subject to the MLR Regulation

The IFR demands that health plans permit, or by contract require, access for HHS audits of parent organizations, related entities, contractors, subcontractors, agents or transferees that "pertain to any aspect of the data reported to HHS or to rebate payments calculated and made under this part."⁶ According to the plain language of this section, every provider who submits a claim, and every network participant whose costs are somehow included in the calculation of a MLR will need, as a result of providing health care to employer groups or individuals, to agree to make its books, records, physical facilities, computers, and all other data and records open to HHS inspection and audit. Even businesses and other entities that merely provide services to

⁶ 45 CFR §158.501(b).

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those who may submit claims to health plans would be subject to a potential audit under these provisions.

This reflects a substantial – perhaps unparalleled – expansion of federal government activity into the daily operation of participants in the commercial health care system, substantially implicating a range of entities and individuals whose businesses are not, by Congressional design, subject to HHS authority under the MLR.

Attempting to regulate these entities through health plans will have the effect of raising health care administrative costs rather than lowering them to the detriment of consumers. In particular, a more cost effective, and less intrusive and disruptive approach, would be for HHS to simply leverage the existing information already available to it. In this regard, health plans must have internal financial controls in place, they have risk management reports, financial examinations from their state regulators, reports to the Securities and Exchange Commission (SEC) and other federal agencies if they are publicly traded, and myriad other control reports and audits that will provide sufficient information for HHS to determine that charges made to and expenses incurred by the entity are accurate and necessary.

III. Avoid Crowding Out Innovations and Investments in Quality and Limiting Consumer Choices

In numerous places the IFR sets out an approach that threatens innovation in quality and in the design of benefit plans and delivery system payment models.

Threat to Innovations in Quality

The concept of using regulation to define what constitutes innovation or “quality” in health care often invites public suspicion as it gives to regulators the power and burden of effectively deciding what technologies and methods of organizational innovation will be experimented with and where investments will be made. In other sectors, such as technology, it is unlikely that such an approach would be attempted, recognizing the speed with which information moves and change occurs and because of the intrinsically dynamic nature of innovation itself.

Yet, with its specific exclusions and categorical approach to classifying “quality activities,” and its drawing of artificial divisions between activities that contain costs and those that improve quality that is exactly the path the IFR takes. In adopting this approach, the IFR defies vast tomes of research on the problems of variation in care relating to underuse, misuse, and overuse that lie at the heart of both cost and quality issues in our health care system.

Thus, while the IFR acknowledges many existing efforts to improve quality, it overlooks and effectively discourages other more dynamic alternatives such as more generally requiring a

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relationship between qualifying activities and the widely recognized principles of quality such as those espoused in the Institute of Medicine's classic report, "*Crossing the Quality Chasm*."⁷ Moreover, in two specific areas – ICD-10 implementation and fraud prevention – the IFR does not even recognize current and well-established efforts to improve quality. In this regard, it is essential that activities in this area be properly recognized as quality improvement activities under the MLR rule.

Recognizing ICD-10 Implementation as a Quality Improvement Activity

We strongly believe that the definition of health care quality initiatives should include the startup costs that health plans incur in meeting the October 1, 2013 compliance deadline for ICD-10 implementation. The primary reason for the required adoption of the ICD-10 codes is to enhance the ability of the health care community to exchange and use detailed clinical data to deliver higher quality care to consumers.

ICD-10 is not a claims payment system – all health plans have existing capabilities to pay claims. Rather, implementation of ICD-10 will provide health plans and health care providers an expanded understanding of diagnoses and procedures at institutional settings of care, thereby enhancing the ability of providers and plans to categorize disease states, document medical complications, and track care outcomes. These advances, in turn, will support efforts to gain a deeper understanding of disease, causes of death, and ways to make significant improvements in health care quality.

The ICD-10 conversion, which was mandated by the federal government, was not undertaken in order to enhance claims payment capabilities. In fact, HHS has publicly recognized that implementation of ICD-10 represents "a giant step forward toward developing a health care system that focuses on quality" and is one that will "enable HHS to fully support quality reporting bio-surveillance, and other critical activities."⁸

The IFR specifically requested comments regarding the inclusion of ICD-10 costs, noting that there is "general recognition that the conversion to ICD-10 will enhance the provision of quality care through the collection of better and more refined data."⁹ In this regard, we strongly urge HHS to recognize that ICD-10 implementation is a major quality improvement initiative and not merely an administrative task surrounding the payment of claims. The ongoing maintenance of

⁷ Institute of Medicine, "Crossing the Quality Chasm: A New Health System for the 21st Century," (2001). The IOM in this report 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 (including avoiding waste); and (6) equitable.

⁸ CMS News Release, "Proposed Changes Would Improve Disease Tracking and Speed Transition to an Electronic Health Care Environment," (August 15, 2008), accessed at:

<http://www.hhs.gov/news/press/2008pres/08/20080815a.html>

⁹ 75 Fed. Reg. 74877.

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the system, once it is built and operational in 2013, may legitimately be deemed an administrative cost. The “conversion” or investment costs to build the system, however, are clearly being undertaken in order to improve the quality of our nation’s health care system and should be included in the quality portion of the MLR.

Additionally, the preamble notes perceived difficulties in “parsing expenses associated with ICD-10 conversions” in the implementation costs of putting in place the ICD-10 codes.¹⁰ Toward this end, an AHIP study¹¹, published September 2010, focused on those very issues and was able to collect significant data from health plans showing the costs of implementing the conversion from ICD-9 code sets to ICD-10 codes. The study outlines findings, based on a survey of 20 health insurance plans, which indicate an average implementation cost for ICD-10 implementation of about \$12 per member, ranging from \$38 per member for small health plans (less than one million members) to \$11 per member for large plans (more than 5 million members). The overall incremental cost for ICD-10 implementation for all responding plans is estimated to be \$1.7 billion. Since the 20 responding health plans do not comprise the entire U.S. health insurance market, the estimated total system-wide cost for insurers is likely to be in the range of \$2-3 billion.

By demonstrating that conversion and investment costs can be tracked and distinguished from operating or routine maintenance costs associated with adjudicating claims, the report should help put to rest concerns that these expenses cannot be “parsed.” It should also help clear the path to account for these investment costs as quality activities – perhaps on an amortized basis spread over some reasonable period of years.

Recognizing the Role of Fraud Prevention Activities in Quality Improvement

The MLR rule threatens to substantially hinder health plan fraud prevention initiatives, exactly at a time when the government is seeking to emulate these successful programs in other areas such as traditional fee-for-service Medicare. It similarly contradicts the broader universal recognition by the Administration, the HHS Office of the Inspector General, and other leaders in the public and private sectors, that there is a direct link between fraud prevention activities and improved health care quality and outcomes.

The basic problem is that the IFR only provides a credit for fraud “recoveries” – i.e., money that was paid out to providers, then recovered. It does not include the cost of developing and administering anti-fraud programs. This creates a negative incentive, as the primary goal of health plan anti-fraud initiatives is to identify fraudulent claims and prevent payment of those

¹⁰ 75 Fed. Reg. 74876.

¹¹ AHIP Center for Policy and Research, “Health Plans’ Estimated Costs of Implementing ICD-10 Diagnosis Coding,” (September 2010) accessed at: <http://www.ahipresearch.org/pdfs/SurveyICD-10CostsSept2010.pdf>

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fraudulent claims in the first place. Therefore, the MLR regulation provides an incentive to pay out more claims initially – the so-called “pay and chase” scenario – to get credit for their fraud detection and recovery activities, rather than try to manage robust fraud prevention efforts on administrative budgets that are now being capped as a result of the MLR and specific IFR implementation.

This is exactly the wrong kind of incentive, especially given the increased priority of fraud prevention and detection in other places in the health care reform law. A new AHIP report, “*Research Brief: Insurers’ Efforts to Prevent Health Care Fraud*,” bears this out.¹² It highlights how health plans’ programs operate to prevent and detect fraud, and how these programs are focused primarily on preventing fraud from occurring in the first place rather than only recouping funds retroactively after fraud occurs. As the report points out, “The knowledge that health plans have robust anti-fraud measures and controls likely prevents inappropriate billings or claims in the first place.” The direct relationship between these programs and health care quality is clear, and the IFR should encourage, not discourage, these patient-centered quality and safety initiatives.

Threatening Consumer Choice

Section 2718 directs that the circumstances of small and “different types” of plans when crafting the rules for the MLR be taken into account. The IFR ignores this directive in many instances and will have the unintended consequence of discouraging the availability of certain types of benefit plans. The link between the MLR IFR and consumer choice is extremely important and should not be overlooked. Nor should it become a source of proactive government activity to choose which products consumers should have access to. Other implementation efforts, such as those relating to “Essential Benefits,” contain specific provisions related to benefit design – and the public is better served from the standpoint of public debate and a transparent regulatory process if issues related to benefit design are considered in that context.

As an example of our concern, the MLR will make it substantially more difficult for health plans to make high deductible health plans (HDHPs) available to consumers. By Congressional design, these plans are intended to provide consumers a highly affordable coverage option that gives them more control over their spending, allows for consumers to save for health care expenses through a Health Savings Account (HSA), and provides catastrophic coverage protection tied to a statutory out-of-pocket maximum. These consumer-driven HDHP/HSA policies were created in order to allow consumers to have a more direct stake in the cost of their health care. These plans are popular with consumers and employers – with 10 million enrollees

¹² AHIP Center for Policy and Research, “Insurers’ Efforts to Prevent Health Care Fraud,” (January 2011) accessed at: <http://www.ahipresearch.org/pdfs/FraudPrevention2011.pdf>.

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as of January 2010¹³. This is a significant growth in enrollment from 2004 when HSAs were first authorized. By failing to recognize the unique nature of these policies, the IFR threatens to undermine Congress' intent, and could result in depriving consumers the opportunity to obtain or maintain what has become a very popular and affordable coverage option.

For this reason, HHS should include an exemption for HSA policies in the IFR that takes into account the potential volatility of MLR measurements for these products (which is increased by the larger deductible) and the fact that their low premium tends to make their administrative costs – which are often largely fixed – seem higher when looked at on a percentage basis.

IV. Provide for An Adequate “Credibility Adjustment” to Address Volatility and Avoid Solvency Issues Caused by Statistical “False Positives”

A critical concern across the individual, small group, and large group markets is whether the loss ratio for a small block of business in a state is based on enough experience to be “credible” such that if a health plan's experience is below the MLR it is clear that this result (and the requirement to pay a rebate) is not indicative of a “false positive,” or put differently, the result of random statistical fluctuation.¹⁴

The handling of this issue is of vital importance because the structure of the MLR requires that health plans pay rebates in years when their performance is below the threshold but are not allowed to net these effects with experience that is above the thresholds. In practice, plans report high levels of variation from year-to-year that are inversely related to the size of the block of coverage (the smaller the block the greater the variation). In today's market, many health plans manage these effects by balancing the variation across a range of states in which they do business. However, because the MLR is to be calculated on a state-by-state legal entity basis, it is no longer possible to manage this variation through a portfolio approach that balances the effect of random, annual variation in MLR across states for small blocks of coverage (commonly reflecting the occurrence and impact of high cost claims). Likewise, it is not possible to manage this issue through reinsurance based on the expected rules because the cost of purchasing reinsurance is to be treated as an administrative cost under the MLR.

Importantly, the issue of volatility and credibility is not limited to the individual and small group markets, nor is it limited to smaller carriers – recognizing that even large carriers have small

¹³ AHIP Center for Policy and Research, “2010 HSA Market Census,” May 2010 accessed at <http://www.ahipresearch.org/pdfs/HSA2010.pdf>.

¹⁴ The issue of credibility is a long-term issue, but it is especially acute for the 2011 to 2103 period, as the MLR rules do not include 3-year averaging until 2014 when such averaging might help to smooth the volatility of results. As a result, especially during the transition to 2014, health plans face the risk of paying rebates on blocks of business that were appropriately priced to achieve the required MLR level simply due to unavoidable, random statistical fluctuations in claim levels.

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blocks of large group coverage when measured on a state-by-state basis as the MLR IFR requires.

The IFR acknowledges the issues and problems associated with credibility by including a credibility adjusted factor that appears to have been based on a confidence interval of 50 percent as opposed to 80 percent. This implies in any given year a 25 percent chance that the failure to achieve a MLR threshold is the result of random statistical variation, all other things equal. The problem presented by this significant risk of a “false positive” is magnified by the fact that, as noted, random statistical variation creating very high loss ratios in other states (creating financial losses and tapping reserves to pay claims) cannot be netted under the MLR rule with the statistical variation creating lower loss ratios in other states. The AAA has written regarding their concerns about the sufficiency of the credibility adjustment reflected in the IFR, raising issues of stability and potentially impairing smaller competitors in the market.¹⁵ Similarly, the actuarial firm Milliman wrote in their report prepared for the NAIC that: “[T]he use of a two-sided 50th percentile basis would likely be considered a very low confidence interval for a study concerned with plan solvency implications of the MLR refund requirement.”¹⁶

Adding to the problem, there is additional concern that the deductible related adjustments for credibility may pose specific problems for HDHPs that by Congressional design are lower cost and have higher deductibles, making them more susceptible to random statistical fluctuations in MLR measures.

Finally, amplifying our concern about the lack of an adequate credibility adjustment is a further and especially complex provision that denies *any* credibility adjustment at all in 2013 if the relevant block of coverage was under the MLR in each of 2011, 2012, and 2013 after the credibility adjustment in those years. This creates a further risk point for carriers, and penalizes those carriers that attempt to stay in the market and continue providing coverage and choice (even after paying rebates), and threatens to make it extremely difficult for a health plan to stay in the market over the long-term that is subject to this provision. Moreover, this provision is of special concern because, as noted above, 2011 pricing is and typically was set well before publication of the IFR, such that they will have only two years – 2012 and 2013 – to try and avert this increased risk. In sum, this provision by creating a 2013 cliff for plans subject to its effects threatens to lessen competition going into the 2014 market reforms and operation of the exchanges, again to the detriment of consumers and employers alike.

¹⁵ See e.g., American Academy of Actuaries Letter to Steven B. Larsen (November 5, 2010), regarding “Regulatory Implementation of Section 2718 of the Public Health Service Act.”

¹⁶ Milliman NAIC Report, “Credibility Adjustment Factors for Use in MLR Refund Calculations,” (August 31, 2010), p. 12.

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Not only does the IFR not provide a more appropriate credibility adjustment, through the preamble it also specifically rejects the potential use of other sensible and well tried mechanisms such as “high cost claims” pooling and stop-loss type reinsurance that could be employed to lessen volatility. Rather than seek to find ways for these mechanisms to be implemented, the IFR dispenses with this possibility without even requesting additional information from the public on whether these mechanisms could be used to complement the credibility adjustment, and denying consideration of all other potential alternative mitigations.

In addition to these comments, we’ve enclosed additional technical comments to the MLR in the attached enclosure. We appreciate the opportunity to comment on this important initiative. Please feel free to contact me should you have any questions.

Sincerely,
Daniel T. Durham
Executive Vice President
Policy and Regulatory Affairs