



Testimony

for

**House Energy and Commerce Committee
Subcommittee on Health**

**The Unintended Consequences and Regulatory Burdens of the
New Medical Loss Ratio Requirements**

by

Randi Reichel

Mitchell, Williams, Selig, Gates & Woodyard

on behalf of

America's Health Insurance Plans

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I. Introduction

Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, I am Randi Reichel, an attorney with the law firm of Mitchell, Williams, Selig, Gates & Woodyard. I am testifying today on behalf of America's Health Insurance Plans (AHIP), which is the national association representing health insurance plans that provide coverage to more than 200 million Americans. AHIP's members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify on the unintended consequences and regulatory burdens of the medical loss ratio (MLR) requirements established by the Affordable Care Act (ACA). Recognizing that the new MLR requirements have far-reaching implications for health care consumers, employers, and health insurance plans, we believe it is critically important for Congress to closely examine this legislative provision and how it is being implemented.

Beginning in 2011, health plans are required to meet annual MLR requirements of 80 percent in the individual and small group markets and 85 percent in the large group market. This means that health plans must spend a specified percentage of premium revenue on either reimbursement for clinical services provided to enrollees or "activities that improve health care quality." Health plans are required to pay rebates to enrollees if they fail to meet the MLR requirements. On December 1, 2010, the Department of Health and Human Services (HHS) issued an interim final rule for the implementation of the new MLR requirements, based largely, but not entirely, on the recommendations of the National Association of Insurance Commissioners (NAIC). AHIP submitted extensive comments to both HHS and the NAIC at all stages throughout the regulatory process.

Our testimony focuses on three important areas:

- The unintended consequences the MLR requirements will have in disrupting health care choices for consumers, turning back the clock on quality improvement initiatives, stifling innovation by health plans, and reducing access to agents and brokers;

- The regulatory burdens and administrative costs the MLR requirements will impose on businesses and health plans; and
- Our recommendations for mitigating coverage disruptions and other adverse impacts of the MLR requirements through a transition and by recognizing fraud prevention programs and ICD-10 implementation startup costs as quality improvement activities.

II. Unintended Consequences of the MLR Requirements

The MLR requirements impose an unprecedented new federal cap on the administrative costs of health plans, strictly micro-managing their ability to invest in new initiatives and innovations to benefit their enrollees. This policy will have a number of unintended consequences for individuals, families, and employers.

Disrupting Choices and Coverage

The MLR requirements pose a risk to the health coverage that families and employers rely on today. This risk is exacerbated by the fact that the provision went into effect in January 2011 without a uniform transition period to allow health plans to adjust to the new requirement. Currently, most states either do not have MLR requirements or they have crafted regulatory loss ratio requirements that include existing actuarial standards to avoid market disruption. Without time to make the adjustments and changes needed to comply, some health plans will have no choice but to exit the market altogether. This breaks the promise that those who like their coverage can keep it.

Many state insurance commissioners have raised similar concerns in submitting waiver requests to HHS, seeking relief from the federal MLR standards. To date, 12 states have submitted MLR waiver requests and three of these have been approved with modifications by HHS. Moreover, HHS has acknowledged the validity of the commissioners' concerns in its recent letters to state officials. In a May 13, 2011 letter to Nevada Insurance Commissioner Brett Barratt, HHS stated that "there is a reasonable likelihood that immediate implementation of an 80 percent MLR standard may destabilize the Nevada individual market." HHS expressed "particular concern" that the withdrawal of two large insurers with a combined market share of 24 percent "would

adversely affect the Nevada individual market, potentially leaving their policyholders without coverage.”

Similarly, in a May 13, 2011 letter to New Hampshire Insurance Commissioner Roger Sevigny, HHS stated: “We agree with the NHID that there is reasonable likelihood that, in this case, immediate implementation of the 80 percent MLR standard may destabilize the individual market. We recognize the potential losses that some issuers in the State may incur if the 80 percent standard were applied for 2011 and rebates were required... The possibility of potential losses could lead to issuers exiting the market, leaving consumers temporarily without coverage and reducing options available to consumers.”

The Congressional Budget Office (CBO) also has recognized the potential for strict MLR requirements to force health plans out of the marketplace. In a December 2008 report, CBO stated: “Whether insurers serving the individual and small-group markets could increase their loss ratios simply because they were required to do so is not clear, so the effects of such requirements on those markets are hard to predict. If the requirement was set too high, insurers would probably exit the market.”¹

More recently, a March 2011 study² by researchers at the University of Minnesota concluded that the federal MLR regulation “has the potential to significantly affect the functioning of the individual market for health insurance.” The authors cautioned: “Nine states would have at least one-half of their health insurers below the [MLR] threshold. If insurers below the MLR threshold exit the market, major coverage disruption could occur for those in poor health; we estimated the range to be between 104,624 and 158,736 member-years.”

While the MLR is problematic for all types of health coverage, its impact may be particularly severe in limiting consumer access to high-deductible health plans (HDHPs). By Congressional design, these plans are intended to provide consumers a highly affordable coverage option that gives them more control over their spending, allows 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. 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

¹ Congressional Budget Office, Key Issues in Analyzing Major Health Insurance Proposals (December 2008)

² Jean M. Abraham and Pinar Karaca-Mandic, “Regulating the Medical Loss Ratio: Implications for the Individual Market” American Journal of Managed Care Vol. 17, no. 3 (March 2011)

are popular with consumers and employers – with 10 million enrollees as of January 2010. However, because these lower-cost benefit options are not necessarily less costly to administer on a per-enrollee basis, they naturally will have lower loss ratios and a greater likelihood of being noncompliant with the MLR rule. By failing to recognize the unique nature of these policies, the MLR regulation threatens to undermine Congress’ intent, and could result in denying consumers the opportunity to obtain or maintain what has become a very popular and affordable coverage option.

Undermining Quality and Stifling Innovation

We also have serious concerns that the MLR regulation will turn back the clock on quality improvement by penalizing health plans for investing in certain activities that are highly beneficial to enrollees. Specifically, the MLR regulation falls short by: (1) only allowing recoveries from fraud programs to be counted toward the MLR, while capping expenses to prevent or deter fraud – in other words, rewarding and encouraging only the “pay and chase” system that Congress has moved public programs away from; and (2) failing to recognize as quality expenses the costs of transitioning to the ICD-10 coding system that will allow for better monitoring and tracking of health care quality. In Section IV of this testimony, where we outline our recommendations, we explain the rationale for recognizing both fraud prevention programs and ICD-10 implementation startup costs as quality improvement activities for purposes of calculating MLRs.

Another closely related concern is that the next generation of health plan innovations may be inhibited by the MLR regulation’s approach of capping any expenses that do not meet the four criteria of “activities that improve health care quality.” While the MLR regulation acknowledges many existing efforts to improve quality, it defines health care quality initiatives in a way that is too narrow, thus creating new barriers to investment in the many activities that health plans have implemented to improve health care quality. The recent HHS MLR Technical Guidance of May 13, 2011 notes that their examples are illustrative, not exhaustive. Yet the method of defining a quality improving initiative in the regulation is more restrictive than that recommended by the Institute of Medicine (IOM). A more dynamic approach to promoting investments in quality improvement would use the framework and criteria established by the IOM and the Agency for Healthcare Research and Quality (AHRQ), entities whose primary goal is to promote high quality health care for consumers. Both the IOM and AHRQ have long recognized that there are

multiple components to health care quality and that the goal is to provide care that is safe, effective, patient-centered, timely, efficient, and equitable.³

Health plans have a long track record in developing innovative approaches to payment and delivery system reforms that are helping to ensure greater coordination and less fragmentation in the health care system. These tools and innovations 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. Plan-specific examples, documented in a recent AHIP publication⁴, include offering intensive case management to help patients at high risk of hospitalization access the medical, behavioral health, and social services they need; arranging for home visits by multidisciplinary teams of clinicians; expanding patient access to urgent care centers and after-hours care; and revamping physician payment incentives to promote care coordination. Greater clarity and flexibility is needed in the MLR regulation to ensure that plans can continue to pursue and build upon these initiatives.

Although the MLR regulation exempts costs associated with certain quality improvement activities, this exemption may not include vital research and data collection efforts. For example, health plans are increasingly using their own claims databases, along with publicly available claims and administrative cost data, to pinpoint indicators of sub-optimal care, such as high rates of hospital readmissions, medical errors and other adverse events, and higher-than-average mortality or morbidity rates. Health plans may use this information in developing their provider networks or in providing information directly to patients. Because this research is not directly related to patient outcomes, it likely would be counted toward administrative costs – not as a quality improvement activity – under the MLR regulation. Therefore, such research could be the first to be eliminated if a health plan's operations were near the MLR threshold.

The importance of continuing – and building upon – health plan initiatives to reduce preventable hospital admissions, readmissions, and emergency room visits is demonstrated by a series of

³ Institute of Medicine, “Crossing the Quality Chasm: A New Health System for the 21st Century,” (2001)

⁴ AHIP Center for Policy and Research, Innovations in Reducing Preventable Hospital Admissions, Readmissions, and Emergency Room Use (June 2010)

recent AHIP studies, conducted over the past two years by our Center for Policy and Research, which have compared certain utilization measures, including hospital readmission rates, for enrollees in the Medicare Advantage program and the Medicare fee-for-service (FFS) program. Our research findings demonstrate that health plan innovations are helping to keep patients out of the hospital and avoid potentially harmful complications:

- Based on a risk-adjusted comparison of patterns of care among patients enrolled in two large, multi-state Medicare Advantage HMO plans and in the Medicare FFS program, we found that the Medicare Advantage plans improved health care for their enrollees by reducing emergency room visits by 24 percent, reducing hospital readmissions by 39 percent, reducing certain potentially avoidable hospital admissions by 10 percent, and reducing inpatient hospital days by 20 percent.⁵
- Based on an analysis of hospital discharge datasets in nine states, we found that risk-adjusted hospital readmission rates were about 27-29 percent lower in Medicare Advantage than in Medicare FFS for each enrollee, 16-18 percent lower for each person with an admission, and 14-17 percent lower for each hospitalization.⁶
- Based on an analysis of data on gaps in time between hospital admissions and discharges in five states, we found that risk-adjusted 30-day readmission rates per hospitalization were about 12-18 percent lower in Medicare Advantage than in Medicare FFS, that risk-adjusted 30-day readmissions per patient with an admission were 12-27 percent lower in Medicare Advantage among patients with at least one admission, and that 30-day readmissions per enrollee (including enrollees not hospitalized in a year) were 22-43 percent lower in Medicare Advantage.⁷

These studies consistently show that the innovations developed by private health plans are reducing the need for preventable hospitalizations. As a result of this success, health insurance plans not only are improving the health and well-being of their enrollees, but also achieving greater efficiencies and cost savings. Health reform should encourage – not impede –

⁵ AHIP Center for Policy and Research, Working Paper: Comparisons of Utilization in Two Large Multi-State Medicare Advantage HMOs and Medicare Fee-for-Service in the Same Service Areas (December 2009)

⁶ AHIP Center for Policy and Research, Working Paper: Using State Hospital Discharge Data to Compare Readmission Rates in Medicare Advantage and Medicare's Traditional Fee-for-Service Program (May 2010)

⁷ AHIP Center for Policy and Research, Using AHRQ's 'Revisit' Data to Estimate 30-Day Readmission Rates in Medicare Advantage and the Traditional Fee-for-Service Program (October 2010)

investments in these initiatives. However, there is some uncertainty about whether many of these now time-tested and successful initiatives would have been permissible had the MLR requirements been in place during their development. We are concerned that the potential lack of flexibility and lack of certainty in implementation standards in the regulation will stifle similar forward-looking and innovative programs in the future.

Reducing Access to Agents and Brokers

Finally, the MLR regulation includes commissions paid to licensed agents and brokers in the MLR calculation. This decision, unless it is reversed, will reduce individuals' and small employers' access to agents and brokers who provide a valuable service to help them find the coverage that best meets their financial and health care needs.

In a health care system that is highly complex, extremely costly and constantly changing, consumers and employers value the services of trusted advisors who can assist them in making coverage decisions that best meet their specific needs and circumstances. Unfortunately, the current MLR regulation threatens the ability of consumers to obtain these vitally important personalized advisory services. AHIP believes that broker compensation should be removed from the MLR calculation to prevent millions of individual and small group customers from losing access to the services of trusted health benefits advisors.

This issue has significant potential to create disruptions in coverage and, as a result, reinforces the need for establishing a transition to the 2014 reforms as we discuss in our recommendations in Section IV. Establishing a transition policy to move from the current system to the new system in 2014 will help ensure that the MLR regulation does not undermine access to the valuable services provided by agents and brokers.

III. Regulatory and Administrative Burdens

The MLR regulation imposes significant regulatory burdens on employers and health plans, and ultimately will have the unintended consequence of increasing administrative costs across the health care system, rather than decreasing them. This runs counter to the President's Executive Order on regulatory streamlining which recognizes that "regulations have costs."⁸

⁸ Executive Order 13563, "Improving Regulation and Regulatory Review" (January 18, 2011)

By imposing an open-ended obligation on health plans for the distribution of rebates in a group coverage setting to employees even where health plans lack the information to determine the appropriate distribution, the regulations establish an unnecessarily burdensome framework for health plans and employers to navigate. Lacking a “safe harbor” outlining reasonable activities that can be undertaken to fulfill this requirement, the ultimate impact of the requirement will be to cause employers, especially small employers, to devote scarce resources to compliance activities that may provide little value to them or their employees.

Meanwhile, health plans will face higher administrative costs due to a variety of new reporting and compliance activities that go far beyond what plans currently are required to undertake. This will necessitate the creation of new information technology systems, contracts, and administrative compliance centers to address and manage the complexity of the proposed requirements, and the unprecedented involvement of the federal government into the records of plans and their business partners.

We want to highlight three areas where the MLR regulation overreaches by imposing requirements not established by the statute and not recommended by the NAIC:

- The regulation goes far beyond the ACA’s requirement that health plans pay rebates when they fail to meet the MLR requirement. It takes the additional step of holding health plans fully liable for the calculation and dissemination of rebates to employees in group plans, without recognizing that it is unreasonable to hold plans responsible for making payments based on the information of entities they do not control, and being subject to penalties for late payments even if the entities have not provided the necessary information for plans to act on. The unintended consequence of this policy is likely to be a significant increase in administrative costs tied to new audit processes and procedures designed to assess compliance for both health plans and employers.
- The regulation contains language and examples suggesting that when a health plan pays a vendor, those vendors must report the types of costs in their billings: what percentage is for quality improvement activities and what percentage is for administrative costs. The health plan is responsible for ensuring that this cost breakout is accurate. This requirement creates a

system that increases administrative costs for insurers without providing any new value to consumers.

- The regulation requires 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.”⁹ This reflects a significant 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. We believe HHS should consider other options for achieving appropriate oversight without creating an unnecessarily burdensome regulatory environment effecting virtually every entity contracting with a health plan.

AHIP has reached out to our member plans, seeking feedback on the costs they will incur in complying with the new MLR requirements. Because the regulation is relatively new, many health plans are only beginning to tally its costs and assess its implications. However, the preliminary information¹⁰ provided by our members indicates that the initial costs of implementing the MLR will be substantial for many plans – necessitating the installation of new accounting systems, new forms of data collection, and increased auditing costs to prove compliance with the MLR calculations and rebates. Some large, multi-state plans have identified preliminary compliance costs exceeding \$20 million.

Three major themes emerged from our discussions with our member health plans: (1) the requirement for health plans to break out administrative and quality-of-care expenses at provider and vendor levels will require new accounting and system development costs; (2) the requirement to pay rebates directly to employees and former employees in group plans is problematic; and (3) the auditing costs to prove compliance with MLR calculations and rebates could be substantial in some cases.

In addition, we anticipate that the compliance costs of the MLR regulation are likely to have the greatest impact on health plans with a large portion of their enrollment in the small group and individual markets, where MLRs are commonly below 80 percent. MLRs are lower for

⁹ 45 CFR §158.501(b)

¹⁰ AHIP Center for Policy and Research, The Federal Medical Loss Ratio (MLR) Calculations – Background and Initial Costs of Compliance (June 2011 – forthcoming)

individual policyholders and the smallest groups for two reasons: (1) the costs of servicing individual and small-group policies tend to be higher than for large groups (where employers assume many administrative functions); and (2) individual and small-group policies tend to have lower benefit levels (such as higher deductibles or copayments) and thus may have lower premiums.

Overall, it is clear that health plans expect to incur significant new administrative costs to comply with the MLR regulation. The initial compliance costs – especially those relating to accounting, auditing, and contracts with providers and employers – likely will exceed the estimates that accompanied the regulation by a substantial amount for many health plans.

IV. Recommendations for Mitigating the Adverse Impacts of the MLR Requirements

In an effort to mitigate the adverse impacts of the MLR regulation, AHIP has offered several recommendations that would take important steps toward protecting consumers and employers from the unintended consequences and regulatory burdens of the MLR. These include implementing an effective transition to the 2014 reforms for all markets and, additionally, recognizing fraud prevention programs and ICD-10 implementation startup costs as quality improvement activities.

Adopting an Effective Transition to the 2014 Reforms

We have urged 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 the ACA's major insurance market reforms. Recognizing that state standards for MLRs were either lower than the federal standard, crafted to include existing actuarial standards to avoid market disruption, or did not exist in some states prior to the ACA, we have asked HHS to adopt a predictable and effective transition plan to reach the individual, small group, and large group markets.

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

Similarly, the large group market typically has not been subject to MLR requirements. This reflects the customized nature of benefit packages and associated cost and quality programs often demanded by large group purchasers. The imposition of the MLR standards 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.

To further emphasize the need for an effective transition, we point out that rates currently 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.

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:

Differences Between Pre- and Post-2014 Market & Regulatory Structure	
2011-2013	2014+
<p style="text-align: center;"><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 style="text-align: center;"><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 style="text-align: center;"><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 style="text-align: center;"><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 style="text-align: center;"><i>Distribution channel through agents & 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 style="text-align: center;"><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

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 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.

A transition 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.

Providing for An Adequate “Credibility Adjustment” to Address Volatility

A critical concern across the individual, small group, and large group markets is whether the MLR for a small block of business in a state is based on enough experience to be “credible” to ensure that if a health plan fails to meet the MLR standard, this result (and the requirement to pay a rebate) is not due to random statistical fluctuation.

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. This means that in years when plans lose money, they cannot recoup those losses, but when they are successful in other years, they must pay it out to policyholders. In effect then, in the years in which plans sustain financial losses, they are never permitted to recover them.

In practice, there are high levels of variation in claims from year-to-year. This disproportionately impacts smaller plans or health plans with smaller blocks of business (even larger plans with small blocks of business), because the smaller the block, the greater the

variation that can be caused by even one critical or large claim. In today's market, many health plans manage these effects by balancing the variation across a range of states in which they do business, or across their entire book of business if they only operate in one state. However, because the MLR is to be calculated on a state-by-state legal entity block-of-business basis, it is no longer possible to manage this variation through a portfolio approach that balances the effect of random, annual variation in claims (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.

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

The regulation 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 the 80 percent confidence interval recommended by the American Academy of Actuaries. The Academy has written regarding its concerns about the sufficiency of the credibility adjustment reflected in the regulation, raising issues of stability and potentially impairing smaller competitors in the market. Similarly, the actuarial firm Milliman wrote in its 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.”

Finally, the MLR regulation contains a highly 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. Moreover, this provision is of special concern because 2011 pricing is and typically was set well before publication of the regulation. This means that plans will have only two years – 2012 and 2013 – to try and avert this increased risk. In sum, by creating a 2013 cliff for plans subject to its effects, this provision threatens to lessen competition going into the 2014 market reforms and operation of the exchanges, to the detriment of consumers and employers alike.

In light of these serious concerns, we believe the credibility adjustment in the MLR regulation should be strengthened to address volatility and ensure that small blocks of business can withstand purely random variations in the frequency or severity of claims.

Recognizing the Role of Fraud Prevention and Credentialing Activities in Quality Improvement

Health insurance plans devote significant resources to fraud prevention and detection programs as part of a broad-based strategy for improving health outcomes and achieving the optimal use of health care dollars. Recognizing that fraud has far-reaching implications both for health care costs and quality, health plans have developed cutting-edge techniques to identify fraud and halt practices that lead to substandard care – including the delivery of inappropriate or unnecessary services that may harm patients. These efforts involve the use of special investigations units (SIUs) that are staffed with qualified personnel, including many with statistical, medical, and law enforcement experience. These SIUs perform sophisticated tasks that include investigating claims, coordinating with law enforcement personnel, training in-house personnel to identify and report possible fraud, developing and using sophisticated software to identify possible fraudulent claims, initiating civil actions seeking to recover improper claims payments, and preparing “evidence packages” of suspected fraudulent providers for the benefit of law enforcement entities.

These health plan anti-fraud initiatives are strongly focused on preventing fraud before it takes place, rather than “paying and chasing” after the fact. This approach serves as a powerful deterrent in preventing not only inappropriate billings, but more importantly, preventing inappropriate delivery of unnecessary or inappropriate services from occurring in the first place. The success of health plans’ fraud prevention initiatives is evidenced by the fact that government programs now are incorporating these innovative private sector practices.

Given the role that health plan fraud prevention and detection programs have played in establishing effective models for public programs, improved data for law enforcement, and successful prevention efforts, we believe the MLR regulation’s treatment of such programs should be reevaluated. The specific concern is that the MLR regulation only provides a credit for fraud “recoveries” – i.e., funds that were paid out to providers and then recovered under “pay and chase” initiatives. It does not include the cost of developing and administering anti-fraud

programs that detect fraud before claims are paid and in the process protect consumers, purchasers, and patients. As a result, the regulation would penalize health plans for committing resources to innovative programs that prevent and detect fraudulent conduct or prevent the delivery of unnecessary services or care.

By taking this approach, the MLR regulation's treatment of fraud prevention expenses works at cross purposes with new government efforts to emulate successful private sector programs, and it is at odds with the broad recognition by leaders in the private and public sectors that there is a direct link between fraud prevention activities and improved health care quality and outcomes.

Similarly, the MLR regulation categorically excludes provider credentialing from the definition of activities that improve health care quality. As now recognized in government programs, provider credentialing is a critical function that helps ensure, among other things, that the providers from whom an individual or family seeks care are properly licensed and qualified – thereby contributing directly to patient safety.

We are urging a reconsideration of potential options for the treatment of fraud prevention and credentialing programs. Excluding these expenses is contrary to the health reform goals of developing a system to deliver consistently high quality care, optimizing the use of health care resources, and enhancing anti-fraud cooperation between private and public entities.

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 goal of ICD-10 was to 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 would, in turn, 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.”¹¹ Additionally, the MLR regulation 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.”¹²

An AHIP study¹³, published in September 2010, collected significant data from health plans showing the costs of implementing the conversion from ICD-9 to ICD-10. 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.

To view the broader implications of ICD-10 implementation costs, it is important to recognize that health plan investments in information technology (IT) infrastructures are consistently challenged to meet the needs of the populations they serve and the growing demands of federal and staff regulators. Numerous reports have stressed the need for timely health information exchange both to improve patient outcomes and efficiency in care delivery. The HITECH Act and other legislative and regulatory requirements point to the need for sustainable health IT infrastructures across the health care delivery system to enable the exchange of such information at the point of care, inclusive of clinically-enriched administrative data available from health plans such as recent care received, missed preventive screenings, and alerts pertaining to medication interactions or recalls. Such infrastructures require ongoing investments in transitioning existing health plan IT systems, experienced staff and other resources that consistently compete with ICD-10 requirements. Other important investments pertaining to health information exchange that will improve the overall efficiency and effectiveness of the health care system are being delayed to meet the arbitrary ICD-10 timelines.

¹¹ CMS News Release, “Proposed Changes Would Improve Disease Tracking and Speed Transition to an Electronic Health Care Environment” (August 15, 2008)

¹² 75 Fed. Reg. 74877

¹³ AHIP Center for Policy and Research, “Health Plans’ Estimated Costs of Implementing ICD-10 Diagnosis Coding” (September 2010)

We have strongly urged 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 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.

Recognizing Promising New Approaches to Cost Containment

At a time when the nation is facing a health care cost crisis, we believe the MLR regulation should recognize the promising new strategies that health plans are employing to achieving cost containment. To discourage investment in these initiatives is penny-wise and pound-foolish.

Health plans are leading the way in developing cost containment strategies that promote administrative simplification, advance health information technology, adopt payment models that reward quality and value, encourage clinical decision-making based on best evidence, empower patients to more effectively engage in the health care system, and design benefits that encourage consumers to choose the safest, highest quality and most cost-effective drugs, devices, and procedures. The broad range of strategies used by health plans to contain costs should be encouraged by the MLR regulation, rather than undermined.

A Health Care Cost Summit recently sponsored by AHIP highlighted a new “shared incentive” payment model launched by one of our member plans in partnership with several large health systems. Under this innovative program, the health plan gradually phases down the fee-for-service portion of reimbursements while adding payments tied to measurable improvements in health care quality and the overall cost of care. A list of quality, outcomes, wellness, and patient satisfaction measures is used to evaluate improvement in providing care for chronic illnesses such as diabetes, heart disease, and hypertension. Over the length of the health plan’s contract with participating care systems, the proportion of payments tied to quality and cost become the dominant reimbursement and incentive system. The gradual shift toward incentive-based payment is intended to allow health care providers to transform health care delivery without putting their solvency at risk. As part of the new model, the health plan shares data with health care providers to identify and address cost drivers and quality gaps so they can improve care processes. This initiative is just one example of the types of innovative strategies that health

plans are developing and that should be encouraged by the MLR regulation to achieve meaningful cost containment.

Finally, health care spending is impacted by certain dimensions of the MLR regulation that discourage or even disadvantage certain care management and quality initiatives. These include, for example, the potential squeeze on quality improvement initiatives or other innovative programs, failing to recognize the value of ICD-10 implementation startup costs, and failing to include the cost of fraud prevention and detection. If administrative cost pressures discourage investments in these areas, medical care costs will go up. This is a perverse incentive that should be avoided at all costs.

V. Conclusion

Thank you for considering our perspectives on the new MLR requirements and the likely impact on consumers and the marketplace. We stand ready to work with the committee to advance a high quality, affordable, patient-centered health care system.