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Dean Cameron, Chair
Jessica Altman, Vice Chair
Medical Loss Ratio Quality Improvement
Activities (B) Subgroup
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 700
Washington, DC 20001

Re: Comments on potential changes to the definition of "Quality Improvement Activities" in the medical loss ratio (MLR) formula

Dear Chair Cameron and Vice Chair Altman:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments on potential changes to the definition of "Quality Improvement Activities" in the medical loss ratio (MLR) formula. Based on the data analyzed by the AMA, we believe that the MLR is working as the National Association of Insurance Commissioners (NAIC) and Congress intended to protect patients. As such, absent clear data and other evidence showing otherwise, it is premature to make any changes to the MLR.

This comment letter discusses the intent of the MLR, how it has functioned since implementation, and makes recommendations to maintain a strong MLR standard while also ensuring that health insurers and others continue to abide by the MLR's intent to protect consumers. As discussed below, the AMA believes that the MLR is an important tool in addressing value in health insurance, but extreme care must be taken when considering changes to any of the requirements. The AMA, therefore, would support the NAIC undertaking a thorough review of how insurers are claiming medical and quality expenses. We believe that this detailed, deliberative process would benefit consumers – and would help ensure that a strong MLR standard is maintained.

The AMA also encourages the NAIC – as well as state regulators – to engage insurers, consumer representatives and other key stakeholders in an open and transparent evaluation of how the current rules are being interpreted and implemented with an emphasis on uniformity in meeting these requirements. The AMA believes this is an important component to ensure the affordability of health care, and, essentially, the value that patients receive from their health care premiums.

Background

The MLR standard is a consumer protection contained within the Affordable Care Act (ACA) that requires health insurers to spend a reasonable percentage of health insurance premiums on patients' medical claims. If an insurer does not spend the required percentage (at least 80 percent in the individual and small-group markets and at least 85 percent in the large-group market), then the insurer must provide a rebate to the patient or the patient's employer.

The ACA specifies that the medical loss ratio also will include "activities to improve health care quality" in addition to direct medical expense in the numerator. In the ACA regulation, the MLR is calculated as follows:

$$\text{Medical loss ratio} = \frac{\text{medical expenses + expenses for quality activities}}{\text{Premiums – federal/state taxes and licensing/regulatory fees}}$$

The ACA allows for 15 percent of premium dollars (for large group markets) and 20 percent (for small group and individual group markets) to be spent on administrative expenses or retained as a contribution to profit. There is ample allowance for additional marketing and sales costs within this percentage of premium dollars to be spent on administrative expenses. The understanding that agent and broker fees and commissions are included as part of the premium is also reflected in long-standing industry practice and state premium tax calculations.

Agent and broker fees and commissions are not part of the numerator in the MLR – they are not considered to be either medical expenses or expenses for quality activities. The AMA believes that agent and broker fees and commissions are quintessential administrative expenses and should continue to be excluded from the MLR in this fashion. Health insurance agents and brokers are commissioned to market and sell health insurance policies on behalf of health plans. These services, and any associated customer service, are core health plan administrative costs. Agent and broker fees and commissions do not meet the definition of a quality-related expense.

A strong standard needs to be maintained for how "quality improvement" and "administrative expenses" are defined. Without these criteria, there would be significant latitude for insurers to creatively categorize cost containment, contracting, marketing and other administrative expenses as "quality improvement activities."

Creating the MLR

In creating the MLR, Congress looked to the NAIC, which held dozens of meetings, conference calls and hearings to ensure that all stakeholders had fair opportunity to present their views. The original intent of the MLR standard was to "provide value to policyholders, but also to create incentives for issuers to become more efficient in their operations."[1] Regulations to implement the MLR standard – as drafted and unanimously approved by the NAIC – underscore the NAIC's interest in maintaining a strong MLR

[1] See, generally, Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule, 45 CFR Part 158, (Dec.1, 2010).

standard.[2] Since the ACA was implemented, the MLR has worked as the NAIC and Congress intended. According to a 2015 Commonwealth Fund study, "total consumer benefits related to the MLR amount to more than $5 billion in the first three years due to savings of over $3 billion and almost $2 billion in rebates."[3]

The AMA recognizes the MLR as an important component in ensuring value for patients' health insurance premiums and costs. In fact, the hundreds of millions of dollars returned to consumers each year shows the MLR's positive impact. Moreover, several reports, including a May 2015 report from the Robert Wood Johnson Foundation found that the MLR, in part, has contributed to reductions in insurers' administrative costs and increased efficiencies in health insurance markets – both of which provide long-term benefits to consumers.[4]

2013: Insurers try to adjust the formula

The NAIC remains the main forum for discussion of the MLR. In 2013, the NAIC considered – but did not adopt – a proposal to adjust the three-year averaging model proposed by insurers to allow health insurers the ability to include prior year rebates in the MLR three-year calculation. Under the ACA, beginning in 2014, any rebate owed to consumers is calculated based on the average MLR (ratio) over the prior three years. Unlike a single-year calculation, a three-year averaging model benefits insurers by enabling them to use well-performing years to help pull up their averages in non-compliant years. This also provides insurers with protections against fluctuating markets compared to a single-year MLR calculation.

The AMA and the NAIC Consumer Representatives argued that if Congress intended to allow this, they could have specifically chosen to do so. They did not. In fact, there was no justification for allowing insurers to count prior year rebates in the three-year average other than enabling insurers to thwart the intent of the MLR.

2015: Insurers want to expand the definition of "quality"

Now, health insurers have proposed that the NAIC broaden the definition of what constitutes a "quality improvement activity" (QIA) to include various fraud detection and prevention activities among other adjustments.[5] Commissioners at the NAIC, however, expressed their skepticism to expanding QIA, noting, among other things, that the NAIC's previous recommendations to the U.S. Department of Health and Human Services (HHS) emphasized that initiatives that would qualify as a QIA should meet clear criteria,

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[2] National Association of Insurance Commissioners "Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio for Plan Years 2011, 2012 and 2013 per Section 2718(b) of the Public Health Service Act. Transmitted October 27, 2010. Available at http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf

[3] The Commonwealth Fund, "The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 3." McCue, Michael J. and Hall, Mark A. Commonwealth Fund pub. 1808 Vol. 6, March 2015, available at http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/mar/1808_mccue_med_loss_ratio_year_3_rb.pdf

[4] Lisa Clemans-Cope, Bowen Garrett, and Doug Wissoker, Robert Wood Johnson Foundation and Urban Institute, Health Insurer Responses to Medical Loss Ratio Regulation: Increased Efficiency and Value to Consumers, May 2015, available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420250

[5] *See*, America's Health Insurance Plans Comments to the National Association of Insurance Commissioners MLR Quality Improving Activities (B) Subgroup, NAIC Fall National Meeting, November 20, 2015. Available at http://www.naic.org/meetings1511/committees_b_medical_loss_ratio_quality_improvement_sg_2015_ahip_testimony.pdf

including being capable of being objectively measured, of producing verifiable results and achievements, being evidence-based, nationally recognized by professional medical associations, directed specifically at health improvements for individual enrollees, and other requirements.[6] As recommended by the AMA, NAIC Consumer Representatives and others, a QIA would not qualify based on subjective, speculative or hypothetical benefits.

Moreover, the AMA agrees with the NAIC Consumer Representatives, that before any changes are made to the list of approved QIAs, the NAIC "review carefully whether currently claimed quality improvement expenses meet regulatory requirements and only then consider whether claimed new innovations in quality improvement activities meet the criteria established under the regulation based on the NAIC's recommendations, and thus could be included in the list of approved activities."[7]

In a list of activities that insurers may already be counting as a QIA, there are many that are of questionable validity. This includes: claiming QIA expenses for undefined activities such as "services provided by sources outside the company;" "prior authorization;" "overhead allocation;" "Explanation of Benefit notices;" undefined "internationalization review of all new services;" "utilization management;" "prescriber detailing;" "high performance network designation;" and other activities[8] that may or may not qualify, but the lack of specificity limits the ability to effectively review the relationship between the activity and the intent of the NAIC and HHS.

Impact of MLR regulation

Clemens-Cope, Garrett, and Wissoker (2015) examined 2010 to 2012 changes in the MLR and its underlying components to determine whether the ACA regulation has had its intended effect in the individual and small group markets.[9] Their research suggests that it has, with a particularly large impact in the individual market.

In order to better understand the regulation's impact, the authors looked at the MLR in two ways. The first, simple measure (traditional MLR) is the ratio of paid medical claims to premiums. The second (net MLR) is closer to, but not exactly the same as, the ratio as defined in the ACA regulation. In addition to claims, the numerator of net MLR also includes rebates and expected rebates, reinsurance expenses, quality improvement expenses, and deductible fraud and abuse detection and recovery expenses. The denominator includes net premiums rather than premiums. Net premiums adjust premiums for taxes and fees (they are subtracted) as well as other adjustments defined by NAIC. Clemens-Cope, Garrett, and Wissoker (2015)

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[6] *See*, generally, draft minutes, Medical Loss Ratio Quality Improvement Activities (B) Subgroup, National Harbor, Maryland. November 20, 2015. Available at http://www.naic.org/documents/committees_b_medical_loss_ratio_quality_improvement_sg_1511_meeting_minutes.pdf

[7] Testimony from Consumer Representatives To the MLR Quality Improvement Activities (B) Subgroup, NAIC Fall National Meeting, November 20, 2015. Available at http://www.naic.org/documents/committees_b_medical_loss_ratio_quality_improvement_sg_1511_consumer_reps_testimony.pdf

[8] *See* "Q1 Expenses" provided by the NAIC MLR Quality Improvement Activities (B) Subgroup on November 20, 2015 at the NAIC 2015 Fall National Meeting **in** National Harbor, Maryland. File available at http://www.naic.org/meetings1511/committees_b_medical_loss_ratio_quality_improvement_sg_2015_qi_expenses.xlsx

[9] See, *supra*, note 4.

also examined the administrative cost ratio (ACR), which is the ratio of administrative expense and claims adjustment expenses to net premiums, and operating margin. Operating margin is a measure of profit. Computationally, it is 1 minus the net MLR and ACR. For example, if the net MLR were 80 percent and the ACR were 15 percent, the operating margin would be 5 percent.

Between 2010 and 2012, Clemens-Cope, Garrett, and Wissoker (2015) estimate that medical expenses in the individual market grew more quickly than premiums. On a per-member per-year (PMPY) basis, average medical expenses increased by 8.9 percent from 2010 to 2011 and by 5.1 percent from 2011 to 2012. In contrast, earned premiums PMPY increased by only 4.7 percent and 3.1 percent.

Because expenses grew more quickly than premiums, the traditional MLR in the individual market increased, from 76.6 percent in 2010 to 81.7 percent in 2012. The net MLR increased from 79.6 percent to 84.9 percent. That the change in the two measures was similar suggests that insurers are complying with the regulation as it was intended, by changing claims paid and/or premiums earned. In contrast, if they were complying with the regulation by issuing rebates or increasing quality improvement expenses, this would show up as an increase in net MLR but would not affect the traditional measure.

The authors also note that the average ACR in the individual market decreased by 2.3 percentage points between 2010 and 2012, and the operating margin by 3.0 percentage points. It is possible that improvements in average loss ratios (and related changes in the ACR and operating margin) occurred because insurers with low loss ratios dropped out of the market. Clemens-Cope, Garrett, and Wissoker (2015) looked at this, and found it not to be the case. Ninety-six percent of enrollment in the individual market in 2010 was in parent companies and insurers that were also present in the market in 2011 and 2012. As such, average loss and administrative ratios and operating margins were similar regardless of whether they were calculated among all insurers, or only those present in the market in each of the three years.

Also speaking to the positive impact of the regulation is that insurers whose loss ratio was below the minimum threshold experienced greater financial changes than insurers who were already meeting or exceeding the minimal threshold. Clemens-Cope, Garrett, and Wissoker (2015) grouped insurers on the basis of their 2010 net MLR – whether or not it was less than 80 percent. This analysis was limited to insurers in the market in each of the three years:

- The traditional MLR of insurers who were under that threshold increased from an average of 66.4 percent in 2010 to 76.7 percent in 2012. The average net MLR increased from an average of 70.3 percent in 2010 to 81.2 percent in 2012.
- In contrast, the average 2010 and 2012 traditional and net MLR of insurers who were at or above the threshold were similar.
- On a PMPY basis, the paid claims of insurers below the threshold increased by 22.0 percent between 2010 and 2012.
- Again, in contrast, the paid claims PMPY of insurers above the threshold increased by only 9.5 percent.

That the ratios of insurers under the threshold changed more than those of insurers who were already meeting the threshold suggests that it was the regulation which led to the financial changes, rather than other market forces.

In the small-group market, Clemens-Cope, Garrett, and Wissoker (2015) estimate that the average traditional MLR increased from 79.1 percent in 2010 to 80.0 percent in 2012, and the net MLR from 83.2 percent to 84.1 percent. As in the individual market, they find little evidence that the increases in loss ratios were caused by insurers with low ratios dropping out. Ninety-three percent of 2010 enrollment was with insurers present in the market in each of the three years, and loss ratios, administrative expense ratios, and operating margins were similar regardless of whether they were calculated among all insurers, or only those with a continued market presence over the three year period.

Furthermore, the U.S. Government Accountability Office (2014) looked at the individual, small, and large group markets and concluded that the percentage of insurers that met or exceeded the MLR standard increased in each market from 2011 to 2012.[10] The largest percentage point increase in those meeting or exceeding the standard occurred in the individual market, a gain of 4.6 percentage points, followed by that in the large group market, a gain of 2.5 percentage points.

McCue and Hall (2015) looked at changes in loss ratios and their underlying components over the 2011 to 2013 period. Their work also suggests that the regulation has worked as the NAIC and Congress intended. In the individual market, they estimate that the median adjusted MLR increased by 2.4 percentage points, from 82.5 percent to 84.9 percent. In addition, total rebates fell from $399.5 million in 2010 to $128.2 million in 2013. In the small and large group markets, they estimate that the median MLR held steady (increasing by less than 0.5 percentage points in both markets) but also noted large decreases in rebates paid. This was especially true in the large group market where rebates fell from $388.2 million to only $79.0 million. Across the three markets, McCue and Hall (2015) estimate consumer gains of over $5 billion – almost $2 billion from paid rebates, and more than $3 billion from reduced overhead.

Conclusion and recommendations

In sum, the MLR standard works precisely as Congress – and the NAIC – intended. As currently implemented, the MLR standard provides greater transparency in the health insurance market for all parties. Insurers must meet an MLR that helps ensure affordable premiums and consumer value. Further, if an insurer does not meet the 80/85 threshold, the insurer must provide a rebate to the patients it covers. That is the appropriate balance previously negotiated – and the appropriate balance that the AMA strongly believes must continue to be in force.

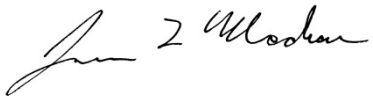
The MLR is a critical and accessible tool in addressing value in health insurance, but extreme care must be taken when considering changing any of the requirements. Therefore, the AMA would support the NAIC undertaking a thorough review of how insurers are claiming medical and quality expenses. We believe that this detailed, deliberative process would benefit consumers – and would help ensure that a strong MLR standard is maintained.

[10] Private Health Insurance: Early Effects of Medical Loss Ratio Requirements and Rebates on Insurers and Enrollees, Report to the Chairman, Committee on Commerce, Science, and Transportation, U.S. Senate, United States Government Accountability Office, July 2014. Available at http://gao.gov/assets/670/664719.pdf

While the AMA certainly supports new efforts to improve quality, a more comprehensive audit may help identify which QIAs fall under reasonable submissions for quality and medical expense. Some likely indicate new innovations, but there may be others that do not – or need further explanation. Specifically, the AMA encourages the NAIC – as well as state regulators – to engage insurers, consumer representatives and other key stakeholders in an open and transparent evaluation of how the current rules are being interpreted and implemented with an emphasis on uniformity in meeting these requirements. Because, while insurers continue to meet their MLR requirements, the AMA is certainly not alone in hearing from concerned physicians and patients about the affordability of health care, and, essentially, the value that patients receive from their health care premiums and cost sharing.

We appreciate the opportunity to provide these comments and for the NAIC's efforts to ensure strong patient protections to the MLR. For questions or more information, please contact Daniel Blaney-Koen, JD, Senior Legislative Attorney, Advocacy Resource Center at daniel.blaney-koen@ama-assn.org or (312) 464-4954.

Sincerely,



James L. Madara, MD