TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

May 14, 2010

Secretary Kathleen Sebelius
Department of Health and Human Services
Attention: DHHS-2010-MLR
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for Comments Regarding Medical Loss Ratios; Section 2718 of the Public Health Service Act as published in the Federal Register on April 14, 2010.

Dear Secretary Sebelius:

The Texas Medical Association (TMA) appreciates this opportunity to comment on critical issues related to the minimum medical loss ratios (MLRs) established by Section 2718 of the Public Health Services Act, as amended by the Patient Protection and Affordable Care Act (PPACA).

TMA is a private voluntary, nonprofit association of Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, its mission is to "Improve the health of all Texans." Its almost 46,000 members practice in all fields of medical specialization. It is located in Austin and has 119 component county medical societies around the state.

TMA has a keen interest in promoting consumer and patient protection laws relating to health insurance transparency. Establishing a minimum medical loss ratio at the state level has been a legislative priority for TMA (as part of its proposed Health Insurance Code of Conduct reforms) over the last two legislative sessions. TMA strongly contends that establishing a meaningful, uniform minimum loss ratio is vital to ensuring that consumers/patients: (1) receive an appropriate level of medical care in exchange for their insurance premiums and (2) are empowered to make informed choices regarding their insurance options.

TMA appreciates the Department of Health and Human Services' (DHHS) efforts in carefully crafting its request for comments and in appropriately seeking and considering stakeholder responses regarding MLR definitions, methodologies, aggregation, and enforcement. The definitions, methodologies, and aggregation recommended by the National Association of Insurance Commissioners (NAIC) and adopted by the Department are central to creating a meaningful MLR floor.

**These definitions and methodologies will effectively determine whether the minimum MLRs established by PPACA are an important first step towards stemming ever-increasing health**

**insurance costs (many of which are attributable to increases in administrative expenses and insurance industry profits) or are merely an official sanctioning of the insurance industry's current expenditure of insurance premium revenues.**[1]

TMA respectfully offers the following comments on medical loss ratios, as published in the Federal Register on April 14, 2010.

## I. Uniform Definitions and Calculation Methodologies

The PPACA established minimum MLRs for individual/small group and large group markets (80 percent and 85 percent, respectively). These ratios were intended to ensure that a minimum amount of health insurance premium revenues are expended on actual medical care, rather than on ancillary services and expenses within the exclusive control of and/or largely for the benefit of the insurer (e.g., executive salaries, profits, sales, underwriting, and administration).

However, to implement a meaningful MLR reporting system and to effectively regulate insurers' expenditure of consumer funds, the NAIC and the DHHS must carefully determine which costs may be considered part of the "medical loss" (i.e., costs related to payment for clinical services and activities that improve health care quality) and which costs fall outside the definition of the "medical loss" (i.e., traditionally those costs that are administrative or related to cost containment). **Without carefully-constructed definitions, health insurers may game the system in a manner such that the MLR percentage floors established by the PPACA exist in form without substance.**

### A. "Medical Losses" Should Be Limited to Those Losses for which the Insurer Has Agreed to Indemnify the Insured

First and foremost, it is important to bear in mind that the MLR is intended to measure the performance of the health plan in undertaking its business purpose (i.e., insurance coverage). At its core, health insurance is simply the promise to pay an amount to or on behalf of the insured person contingent upon the insured person suffering a loss caused by a medical condition, preventative care or a disorder. Consistent with this purpose, only losses that the insurer has agreed to indemnify and that are suffered by the patient should be considered medical "losses" for MLR purposes. All other expenses are simply ancillary to this insurance-risk-related purpose and potentially are subject to health insurer control and/or manipulation.

The MLR should, therefore, measure the insurer's performance in providing insurance — not value-added or cost-containment services. Neither value-added nor cost-containment services are losses or expenses that would be "suffered" by the patient/insured person nor are they items for which the insurer has agreed to indemnify. The fact that the insurer has agreed to provide these services does not modify their character or permit them to now become reclassified as an expense for which the insurer has agreed to indemnify. To permit such a reclassification would be a significant break from historic classifications of cost containment expenditures and would be contrary to the intent of Congress in passing a minimum MLR, which was to ensure that a

[1] Acceptance of assertions and methodologies such as those advocated by the American Academy of Actuaries would, in fact, serve to permit carriers, such as WellPoint, to undertake their current business strategy of administrative cost reclassification with impunity.

minimum amount of premium dollars is spent on actual medical claims (not on value-added or cost-containment expenses).

### B. Cost Containment Costs and Value-Added Expenses Have Some Value But Are Not Medical /Quality Improvement Costs for MLR Purposes

Cost-containment expenses and value-added expenses have traditionally been considered part of the insurer's "administrative costs" by states and other entities (e.g., NAIC) when calculating MLRs, rather than part of the medical loss. In other words, cost containment expenses have not been included in the numerator when calculating the ratio between medical claims costs and premium revenues.

It is imperative that the Department adhere to this previously-accepted accounting methodology in order to ensure a meaningful MLR floor. In an attempt to minimize the impact of the PPACA MLR requirement (and artificially inflate their MLRs), health plans will most likely seek to include or reclassify for purposes of their "medical loss"/quality reporting activities that traditionally were considered administrative or directed at cost containment and that are entirely within the insurers' control, such as:

- **Wellness programs.** Programs offered to patients that suggest better food choices, diet, and exercise; reminders to get certain checkups; and preventive screening exams.

- **Disease management/case management programs.** Programs in which health plans call upon the physician and patient to coordinate the treatment plan and care related to the patient's chronic disease or illness, such as cancer, diabetes, or a high-risk pregnancy.

- **Utilization review programs.** Programs whereby health plans utilize nurses to review requests from a physician for hospitalizations or for certain procedures, then provide an authorization for them to occur.

- **Network development costs.** Costs associated with developing a physician health care network to offer employers and patients, including relationship-building activities, contract negotiations, and the like.

All four of the aforementioned programs may certainly be considered "value-added" services that health plans may offer to employers that assist in "cost-containment" initiatives. However, these services (and other similar services) are appropriate for disclosure as "cost-containment" expenses within the administrative cost MLR, not as medical "loss" and/or quality expenses for MLR rebate purposes. These services are separate and distinct in nature from medical claims costs and should, therefore, be considered and reported separately from such expenditures.

We recognize that value-added programs and network costs are important for employers and patients to consider when making insurance choices. However, once again, it is important to remember that the rebate MLR is designed as a tool to compare the medical costs — the medical claim payout or "loss," if you will — with the premium. That is why there should be separate reporting for cost-containment expenses (as has traditionally been the case in NAIC financial reporting, as discussed below).

## C. The NAIC's Financial Reporting Classifies Cost Containment Expenses as Administrative Costs—Not as Medical Costs

In the NAIC's Accident and Health Policy MLR financial reporting, cost containment expenses are limited to those "expenses that actually serve to reduce the number of health services provided or the cost of such services."[2] NAIC includes as examples of such cost-containment services the following: case management activities, utilization review, fraud and abuse detection and prevention, network access fees, consumer education programs (e.g., disease management/smoking cessation), and expenses for internal and external appeals processes.[3]

Notably, many of the aforementioned cost-containment services (e.g., utilization review) are directed at denying or reducing care. It is difficult for one to see how insurers may re-characterize these expenses—expenses that are so obviously directed at the insurer's bottomline rather than at enhancing the consumer's promised benefits—as part of their "medical loss."

As the average consumer knows (with regard to any product), cost, quality, and value are three entirely separate concepts. To conflate the three concepts into the numerator of the MLR would merely serve to (1) mislead consumers/patients regarding the value of their insurance policy and undermine the transparency that the bill was directed at ensuring and (2) undercut the strength of the MLR minimums and the rebates mandated by the PPACA by artificially inflating insurers' MLRs.

Further, DHHS should not permit "cost containment" measures to be included in the medical loss portion of the MLR, because such reclassification of cost containment expenditures would be in direct contravention to the express language of the PPACA. Under PPACA, only clinical services and quality improvement services are permitted to be included in the rebate MLR numerator.[4] Cost-containment measures are—first and foremost—cost-related (as their name implies). Thus, these costs will generally not fall into either of the two rebate MLR numerator categories (of quality improvement and clinical services) and have no place in the rebate MLR equation.

Additionally, as Senator Rockefeller once stated in expressing initial outrage over insurers' expenditure of premium revenues, the relevant question in assessing MLRs is: "Are [insurers] spending [premiums] to make people well when they are sick and keep them healthy? Or is the money they charge going to profits, to executive salaries, and *to figuring out how to deny care to people when they really need it*?"[5] (emphasis added). Notably, Senator Rockefeller places attempts to deny care (e.g., utilization review) into the same category as other traditionally administrative expenses (e.g., profits and executive salaries).

In alignment with Rockefeller's sentiments, the NAIC guidelines, have long considered "cost-containment" expenses as **administrative** in nature (not quality in nature and not part of one's

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[2] *See* Statement of Statutory Accounting Principles No. 85; finalized June 10, 2002; effective January 1, 2003.
[3] *Id*.
[4] *See* Section 2718(b)(1) Public Health Services Act.
[5] *See, e.g.,* Rockefeller quote in the following article: Chris Silva, *Health Plans Asked to Explain How They Set Rates*, AMEDNEWS; Nov. 18, 2009, *available at*: http://www.ama-assn.org/amednews/2009/11/16/gvsc1118.htm

medical benefits or medical loss). This is true even for case management, disease management, and smoking cessation programs. DHHS should adhere to these classifications when defining those costs which are placed in the numerator of the PPACA rebate MLR.

Despite the American Academy of Actuary's assertion that such some value-added or cost containment services are now "more akin to benefits than administrative expenses,"[6] previous classifications of such expenses by NAIC and insurers themselves (as well as common sense) dictate that these expenses are **not** medical benefits and should not be in included in the MLR rebate numerator. No patient would believe that spending money to deny his medical care is among the health care "benefits" provided to him under this insurance contract. This is a profit-driven service, not a medical care-based service.

Additionally, as previously stated, cost containment measures (including disease management, smoking cessation programs, nurse hotlines, etc.) should be treated as administrative in nature, because these expenses are not related to the insurer's medical loss. Simply put, these value-added services are not costs for which the insurer indemnifies the insured. TMA, once again, urges DHHS to be mindful of the overarching purpose of the rebate MLR when categorizing these services/costs. The purpose of the rebate MLR is to ensure that a minimum amount of premium dollars are expended on health care. Regardless of how strenuously insurers advocate for reclassification of value-added and cost containment costs as part of their medical loss, these costs are simply not an appropriate part of the rebate MLR equation.

### D. **Insurers Have Themselves Treated Value Added and Cost Containment Costs as Administrative in Nature Prior to the Enactment of the Federal Minimum MLR**

Prior to the establishment of minimum medical loss ratio requirements at the state level and federal level, value-added and cost containment costs were treated by many insurers themselves as administrative in nature. For example, the insurer WellPoint has historically considered disease management, case management and nurse hotlines as cost containment expenses.

However, in anticipation of federal regulation tightening MLRs, WellPoint recently began shifting costs that it considered administrative or cost containment in nature to the "medical cost" portion of the MLR, thereby artificially inflating its MLR. For example, a March 17, 2010, electronic message from WellPoint to its investors stated:

> WellPoint's (WLP) medical cost ratio should rise and its overhead expense ratio decline this year as the insurer *reclassifies* various types of costs. Disease management, medical management and a nurse hotline, for example, 'are being *reclassified* because they represent additional benefits provided to our members,' a representative says. They'll now be part of the medical cost ratio, the percentage of premium revenue used to pay members' health-care costs. These are claims-related costs incurred to improve member health and medical outcomes, WLP says. Accounting rules allow the changes, which better align MCR [medical cost ratio]

[6] *See* American Academy of Actuaries, *Critical Issues in Health Reform: Minimum Loss Ratios*, Feb. 2010, *available at*: http://www.actuary.org/pdf/health/loss_feb10.pdf

> with anticipated health reform guidelines, Stifel Nicolaus [a subsidiary of Stifel Financial Corp.] says.[7] (emphasis added).

This action by WellPoint (which is likely to be followed by other health insurers) should beg the question from DHHS: Why are these types of costs suddenly being reclassified as "medical costs" if for no other reason than to manipulate the rebate MLR? If they were not counted as a "medical costs" prior to the enactment of federal and/or state minimum MLRs, why should they be counted as "medical costs" now? Insurers have only sought change in the classification of these costs now that legislative change is upon them. The underlying nature of the costs, however, remains the same.

As stated in a March 31, 2010 *Think Progress* article by Igor Volsky, WellPoint's actions demonstrate both the vulnerability of the rebate MLR metric to manipulation and the need for regulators to be circumspect and precise when defining medical expenses.[8] Mr. Volsky continues by stating that:

> establishing a medical-loss ratio still allows insurers to shift a disproportionate amount of premium dollars into profits. If anything, plans could pay more for certain services (to meet the benchmark), exclude certain benefits from coverage (benefits which would attract a sicker risk pool), or in the case of WellPoint, reclassify some administrative services as medical care *and still meet the mark without necessarily providing more care.*[9] (emphasis added).

These reclassification attempts clearly run afoul of the intent of the PPACA and eviscerate what could be an important consumer/patient protection measure. DHHS should not permit conveniently-timed shifts in long-standing accounting methods to be used to circumvent the spirit or the letter of the new law.

Insurers stand to gain much by making even small shifts in classification of costs, as evidenced by WellPoint's highly-publicized reclassification of expenses. The Committee on Commerce, Science and Transportation's Staff Report for Chairman Rockefeller provides the following insight on WellPoint's administrative cost reclassifications:

> By reclassifying these [previously cost-containment] expenses as medical benefits, the executives projected that WellPoint's 2010 medical loss ratio (which the company calls its 'benefit expense ratio') would increase by 170 basis points, or 1.7%.[10] Because WellPoint expects to collect more than $30 billion in premiums from its commercial health care customers in 2010, this 'accounting reclassification' means that the company

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[7] Quote taken from the following article: Igor Volsky, *WellPoint Reclassifies Costs as "Medical Care" to Meet Reform's Medical Loss Ratio Requirement*, March 31, 2010, *available at*: http://wonkroom.thinkprogress.org/2010/03/31/wellpoint-mlr/

[8] *Id*.

[9] *Id*.

[10] WellPoint investor call and PowerPoint presentation, "WellPoint, Inc. 2010 Financial Outlook Review," at 8 (Mar. 17, 2009) (online at: http://ir.wellpoint.com/phoenix.zhtml?c=130104&p=irol-calendar).

> has converted more than a half a billion dollars of this year's administrative expenses into medical expenses. [11]

Additionally, the Staff Report contains health care industry analyst Carl McDonald of Oppenheimer & Co.'s predictions of future industry-wide cost-shifting to circumvent minimum MLRs.[12] Specifically, the Report states that:[13]

> McDonald predicts that companies will review their current spending and attempt to shift as many expenses as possible from administrative to medical. In one scenario, McDonald posits an 'MLR shift' of 500 basis points, or 5%. He concludes that a key to the insurance industry's profitability over the next several years will be 'how much MLR recharacterization the HHS Secretary allows.'[14]

## II. Aggregation Issues

Next, TMA is aware that there has been some debate over the appropriate level of geographic aggregation permitted when insurers report minimum rebate MLRs under the PPACA. Some stakeholders support aggregation that is national in scope. Absurdly, this form of national aggregation would enable health insurers to report an MLR for its *entire* geographic span of business and to meet the minimum MLR standards even if the insurer's MLRs for certain states or other geographic areas are exceptionally low.

TMA urges DHHS to limit geographic aggregation for MLR rebate reporting to the state level. TMA objects to any more broadly-defined aggregation for the following reasons. First, insurance is typically sold and regulated at the state level. Thus, the state forms a natural basis for aggregation. Second, health insurance exchanges created by health system reform will exist at the state level. Further, the language of PPACA itself provides that MLR minimums may be increased to a "higher percentage as a State may by regulation determine." With potential variations in MLR minimums created by states, national reporting of MLRs would present significant operational problems. Finally, providing information in any broader form than the state level will fail to provide consumers with useful information when selecting an insurance product appropriate for their circumstances.

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[11] U.S. Senate Committee on Commerce, Science, and Transportation; *Implementing Health Insurance Reform: New Medical Loss Ratio Information For Policymakers and Consumers*; Staff Report for Chairman Rockefeller; April 15, 2010; pp.5-6; *available at*: http://commerce.senate.gov/public/?a=Files.Serve&File_id=be0fd052-4ca6-4c12-9fb1-a5e4a09c0667 [hereinafter "Staff Report for Chairman Rockefeller"].

[12] *Id*. at 6.

[13] *Id*.

[14] Carl McDonald and James Naklicki, Oppenheimer & Co. Inc. Equity Research Industry Update, *The Average Person Thinks He Isn't – Minimum Medical Loss Ratio Analysis* (Apr. 8, 2010).

## III. Transparency in Premium Dollar Expenditures by Insurers

One clear purpose of establishing and mandating reporting of a minimum MLR was to create transparency for consumers regarding expenditures of their health insurance premium dollars. Consumers must, therefore, have access to information that is meaningful to them as individuals. Consumers need information drilled down to a level that is both understandable and useful for their decisionmaking. Indeed, this information should include a breakdown of not just the administrative expenses incurred by an insurer, but should also provide details on medical expenses.

The administrative/cost containment expenses of a carrier should separately identify and include, but not be limited to:

- executive salaries;
- commissions and other broker fees;
- marketing;
- recruitment and network development;
- utilization review, disease and case management;
- pharmacy benefit management;
- fraud and abuse detection;
- lobby expenses;
- entertainment and travel expenses;
- information technology development; and
- any home office or other overhead expenses.

Direct medical losses should also be itemized to separately disclose, in the aggregate, payments to:

- hospitals;
- ambulatory surgical centers;
- pharmacies;
- physicians; and
- other health care providers.

The full disclosure and subsequent itemization of insurers' operations will serve to provide regulators with the information they need to evaluate the market place conduct of an insurer. This disclosure will also aid regulators in the determination of appropriate rebates to consumers. Finally, item by item disclosure will also offer insurance consumers the information they need to compare products and make better purchasing decisions.

## IV. Conclusion

Some MLR analysts contend that the starting point for the definition of the MLR upon which rebates are conditioned within the PPACA is more generous to insurers than the definition of MLR that is common in many states and that is currently utilized by the NAIC for financial statements. This contention is based on the debatable assertion that in calculating the PPACA rebate MLR, the premiums (i.e., the denominator) of the MLR may be reduced by federal and state taxes and licensing or regulatory fees. If the Department interprets the statute in that manner, to provide further room for manipulation of this ratio by loosely defining quality improvement services and

medical losses would significantly weaken the PPACA's rebate MLR. Thus, DHHS must very carefully and narrowly construe the statutory language regarding quality improvement services and medical loss.

The Congressional Budget Office (CBO) previously stated that the MLR minimums contained within the health system reform bill reflect a level that most insurers were already meeting.[15] If those minority of insurers who were not previously meeting the MLR standards (under traditional definitions of MLR) are permitted to shift many costs into the medical/quality component (i.e., the numerator) of the rebate MLR, then the law will make little progress towards achieving the stated goal of the legislation (i.e., ensuring that a minimum amount of health insurance premium dollars are dedicated to the actual provision of medical care). Instead, the law would merely sanction the status quo without providing any additional benefit to consumers in terms of transparency or plan value. DHHS must guard against this result by carefully and narrowly drafting its MLR definitions.

Once again, TMA thanks you for the opportunity to provide these comments. If you should have any questions or need any additional information, please do not hesitate to the following staff of the Texas Medical Association: Lee A. Spangler, JD, TMA Vice President, Division of Medical Economics; Patricia Kolodzey, TMA Associate Director, Legislative Affairs; or Kelly Walla, JD, LLM, TMA Associate General Counsel at TMA's main number 512-370-1300.

Sincerely,

Christopher Crow, MD, MBA
Chair, Council on Socioeconomics
Texas Medical Association

[15] Congressional Budget Office, *Budgetary Treatment of Proposals to Regulate Medical Loss Ratios* (Dec. 13, 2009) (online at: http://www.cbo.gov/ftpdocs/107xx/doc10731/MLR_and_budgetary_treatment.pdf).