



Comments of Aetna Inc. before the
Joint Public Hearing of the
Florida Office of Insurance Regulation
And the
Florida health Insurance Advisory Board

May 4, 2010

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Medical Loss Ratio (MLR)

The final regulation should further key goals of health care reform:

I. Quality Improvement and Affordability

- 1) Accurate Quality Definition: The definition of activities that improve health care quality and clinical services must allow for the inclusion of the wide array of insurer functions that provide value for consumers. In addition, the definition should provide a level playing field among different types of insurers and products.
- 2) Scope of Benefits: MLR rules should not apply to HIPAA excepted benefits.
- 3) Exclusion of State and Federal Costs: MLR should be calculated after excluding state and federal assessments, taxes and other costs from revenue.

II. Enhancement of Competition

- 4) Appropriate Aggregation: The large group MLR should be at the aggregated legal entity level for the largest geographic area covered. A combined, state based MLR should be used for the individual and small group markets (at the aggregated legal entity level).
- 5) Market Monitoring: Assure that federal and state regulators have clear direction with established early warning signals to lower MLRs if solvency or competition deteriorates.
- 6) Rolling Averages: Beginning in 2011, insurers should be allowed to calculate MLRs based on three year rolling averages.

III. Administrative Efficiency

- 7) Calendar Years: MLRs should be based on a calendar year basis.
- 8) Rebates: Rebates should take the form of premium credits to current customers. De minimus rebates should be provided to state high risk pools or risk adjustment mechanisms.
- 9) Preemption: Federal MLR rules should preempt state MLR rules.

Legislative Background

The Patient Protection and Affordable Care Act includes the following provisions impacting MLR:

- Insurers are required to submit an MLR report to HHS Secretary
 - MLR requirements are 85% of the large group, 80% for the small group and individual markets
 - Secretary can adjust the 80% MLR in a state if the Secretary determines that such requirements may destabilize the individual market
 - Insurers must provide an annual rebate to enrollees if minimums are not met
 - The NAIC will establish uniform definitions of activities and standardized methodologies for calculation of the MLR, subject to the Secretary's certification
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I. *Quality Improvement and Affordability*

Recommendation #1: Accurate Quality Definition

The definitions of activities that improve health care quality and clinical services should include:

Part A: Activities to Improve Health Care Quality

As the purchaser of health care services for more than 170 million Americans, health insurers play a pivotal role in implementing mechanisms to improve care quality. This role has long been recognized by government agencies such as the Agency for Healthcare Research and Quality (AHRQ), independent accreditation bodies such as the National Center for Quality Assurance (NCQA) and the Utilization Review Accreditation Committee (URAC), and an array of public interest initiatives to advance health quality including the National Association for Healthcare Quality, the American Health Quality Association, the Quality Assurance Project, the NYS Health Accountability Association (and many analogous programs in other states), the National Initiative on Children's Health Care Quality, the Institute for Healthcare Improvement, the National Quality Forum, the Leapfrog Group, Bridges to Excellence and the Center for Payment Reform. Most health plans are required to maintain quality assurance and utilization review programs by state law. Similar requirements are reflected in the Federal HMO Act. Most plans also maintain accreditation by either NCQA or URAC and actively participate in quality improvement initiatives sponsored or supported by the other agencies noted above.

Examples of these quality improvement initiatives include, but are not limited to:

- **Health information technology (HIT), including electronic health records EHRs and protocol-driven care review:** Health information tools allow clinical information to be shared in real time among patients and providers, reducing the risk of medical errors and unnecessary/ duplicative services. These record-sharing mechanisms include EHRs, personal health records (PHRs), and regional health information organizations (RHIOs).
 - Aetna's *Care Engine* technology provides a major enhancement to electronic health records by continuously reviewing member health activities against more than 10,000 evidence-based care protocols to identify gaps in care, opportunities for care improvement and potential health risks associated with adverse care interactions. The Care Engine technology provides alerts called "Care Considerations" to doctors and patients about opportunities for care improvement and potentially even life-threatening risks.
 - Aetna's PHR platform allows members to manage their own health information and also links them to clinical quality and cost information on common medical procedures, physician-specific indicators based on adverse events and overall efficiency, and hospital information about specific diagnoses and procedures, empowering them to evaluate the overall value and cost of care before they access services.
- **Clinical pharmacy activities:** Includes therapeutic effectiveness assessments (e.g., P&T committee), drug interaction monitoring and direct pharmacy services (e.g., mail order delivery, specialty pharmacy delivery). These services facilitate the ability to prevent negative drug interactions, provider prescription errors, and other issues that could negatively impact patient health.

- In 1993 medication errors are estimated to have accounted for about 7,000 deaths.ⁱ Medication errors account for one out of 131 outpatient deaths and one out of 854 inpatient deaths.

Rationale: The activities, of which examples are provided above, are designed to assure that consumers get the best care at the best time -- which leads to higher overall quality of health care. Some of these activities improve quality through information sharing, while others work to reduce medical errors, improve provider services, or protect consumers from problematic services. Ultimately, these functions lead to better outcomes and lower premiums. Many organizations recognize these types of activities as quality enhancing -- such as the NCQA, the National Quality Forum, the Leapfrog Group as well as Statutory Accounting Principle #85.

Part B: Clinical Services

Insurers also conduct several activities associated with the reimbursement of health care providers for clinical services and the arrangement of favorable provider reimbursement rates, including network access fees and payments and other intermediaries who arrange for health care services. Additionally, carriers must conduct contracting, credentialing, quality, cost and satisfaction measurement and reporting, communication, electronic connectivity and appeals. These costs assure an ongoing level of quality within provider networks.

The definition of the terms included as clinical services should be consistent as those used by the NAIC. For example, terms such as Incurred Loss and Loss Adjustment Expense, as included in the legislation, are defined in statutory accounting standards and currently reported annually by insurers. The definition of these items should be consistent with the relevant accounting standards (specifically SAP 50, 54, 55 and 85) and include actual clinical claims paid, claims incurred but not yet reported or paid, estimated claims to be paid pursuant to actuarial standards (i.e., claim and premium reserves) and the cost containment expenses included as component of loss adjustment expenses and enumerated in SAP 85.

Rationale: Different insurers contract with and pay providers in different ways. The type of physician financial arrangement (e.g., staff model HMOs, capitation) determine whether under traditional rules these administrative costs are attributed to the physician or the insurer and, in turn, determine whether those costs are included in the MLR calculation. HMOs with very narrow networks (e.g., staff models) will tend to incur lower administrative expenses under this methodology. To assure a level playing field and support the ability of both models to provide quality health services to consumers, all four items listed above -- provider reimbursements, payments to third parties, incurred loss and other categories of provider payment -- should be considered under the category of clinical services costs.

Recommendation #2: Scope of Benefits

HIPAA excepted benefits are not subject to Minimum Loss Ratio Rules.

These HIPAA excepted benefits include:

- Coverage only for accident, or disability income insurance, or any combination thereof
- Coverage issued as a supplement to liability insurance
- Liability insurance, including general liability insurance and automobile liability insurance
- Workers' compensation or similar insurance
- Automobile medical payment insurance

- Credit-only insurance
- Coverage for on-site medical clinics
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits

Benefits not subject to requirements if offered separately

- Limited scope dental or vision benefits
- Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof
- Such other similar, limited benefits as are specified in regulations

Benefits not subject to requirements if offered as independent, noncoordinated benefits

- Coverage only for a specified disease or illness
- Hospital indemnity or other fixed indemnity insurance

Benefits not subject to requirements if offered as separate insurance policy

- Medicare supplemental health insurance, coverage supplemental to the coverage provided under chapter 55 of title 10, and similar supplemental coverage provided to coverage under a group health plan

Rationale: PPACA minimum loss ratio rules are part of the overall HIPAA framework that includes a set of products that are not subject to reforms. Subjecting these policies to minimum loss ratio rules could thwart their ability to offer critical products to consumers that allow them to access a quality of health services they could not access without coverage.

Recommendation #3: Exclusion of State and Federal Costs

The formula to calculate the minimum loss ratio should exclude state and federal assessments, taxes and other costs from premium revenue. This should include items such as federal income taxes, federal employer payroll taxes, federal excise taxes and other federal regulatory related costs. In addition, state premium taxes, income taxes, property taxes and other regulatory and licensing fees and assessments, such as guarantee fund assessments, charity care assessments, high risk pool assessments etc., should be excluded from premium revenue. This would include items such as New York's HCRA surcharge or the costs associated with normalizing risks such as NYS regulation 146 insurer funded reinsurance pool.

Rationale: The statute clearly intends to exclude these items from the calculation. If the items are not excluded, then it would reduce – or eliminate – the ability of insurers to invest in important services that further quality improvement such as health information technology.

II. Enhancement of Competition

Recommendation #4: Appropriate Aggregation

For purposes of reporting and calculating MLRs:

- Large group: Measure at the aggregated legal entity for the largest geographic area covered
- Individual and small group market: Combined MLR for individual and small group market at state level for the aggregated legal entity

Rationale: Aggregating the groups in this manner will reflect the fact that consumer needs vary based on market segment.

- Large Group Market: Large groups have membership across many states and often prefer to have a single carrier. Blending large group experience across the legal entity level is the most accurate way to assure reasonable distribution across all group clients—and best conforms to the accounting principle of matching costs to associated premiums.

Economist James Robinson warns of the consequences of too narrowly grouping the product on which MLR calculations are based. Robinson points out that since many insurers operate nationally, breaking up their national administrative expenses into component regional or state markets risks incorrectly attributing administrative expenses to specific markets.

In addition, many groups may not have a credible number of lives in individual states. Any requirement to calculate large group MLRs at the state level would increase administrative costs to employers and would reduce the number of insurers capable of serving this marketplace.

- Individual and Small Group Market: If MLRs are required to be calculated separately for the individual and the small group market, many insurers may find it difficult to comply with this requirement and may lead them to exit the individual market. Such exits would reduce competition in a marketplace where consumers in many states already feel their choice is unfavorably constrained.

Recommendation #5: Market Monitoring

Specify that state and federal regulators identify and monitor for early warning signals of the potential market destabilization from MLR requirements and intervene if they occur. In particular, the federal government should lower MLR requirements in any of the following situations:

- Early Solvency Warning: An early warning trigger should be as follows: if a single insurer has a reduction in the risk based capital level of 20%, or the aggregate market experiences a 10% reduction in risk based capital. If this trigger occurs, the MLR should be lowered to avoid the bankruptcy of insurers – and the harm that would bring to consumers and providers.

- Product Withdrawal: This trigger would consist of the withdrawal of 10% of products by market carriers. If this occurs, the market would be considered destabilized and the Secretary must intervene.
- Market Contraction: Another trigger should be if at least 10% of enrollees in the marketplace are impacted by one or more insurers exiting the market. In this case the individual market should be considered destabilized and the Secretary should lower the MLR requirements.

Rationale: According to the American Academy of Actuaries, “Imposing unrealistically high medical loss ratio requirements may threaten plan solvency by making it difficult for premiums to cover claims and expenses.” Having an early solvency warning trigger is critical to avoid this. In addition, if the MLR is set too high, carriers will exit the market. This undermines one of the stated goals of reform – to allow consumers to “keep what they have.” In addition, it would reduce consumer choice and competition in many states.

Recommendation #6: Transitional Rules on Rolling Averages

Reporting, calculation and rebating regarding MLRs should be done on a three year rolling average per state. Beginning in 2011, the Secretary should allow insurers to use a three year rolling average when calculating their MLR.

Rationale: The timeframe (e.g., multi-year, lifetime, annual) over which included costs and claims occur will have a significant impact on the MLR, since high cost investments and the savings they generate may not accrue in the same time period. In addition, administrative costs for a product vary over time. For instance, launching a new product may require more administrative costs than in later years when the product is simply being maintained. Basing the allocation on a three year rolling calculation will also help to smooth out fluctuation in smaller blocks of business. If single years are required for MLR calculations, it would reduce the ability of new insurers to enter a marketplace, or to existing insurers to roll out new products. In addition, the use of single year MLRs could hurt insurers with a smaller level of business in a marketplace since their MLRs may experience higher year to year fluctuation.

III. Administrative Efficiency

Recommendation #7: Calendar Years

MLRs should be reported and calculated on a calendar year basis.

Rationale: Most states base MLR calculations on a calendar year basis. Requiring insurers to report these calculations differently would increase administrative costs and create nonsensical results. Each group (even those enrolled in the same product line) have different *plan years*. This could result in thousands of MLR calculations per insurer throughout the year. The individual market traditionally doesn't use the term "plan year." Consumers generally have "renewal dates" -- with thousands of customers renewing every day of the calendar year.

Recommendation #8: Rebates

The regulation should provide for a fair and administratively efficient mechanism to protect consumers from insurers who fail to comply with minimum loss ratio requirements. The rebate or "penalty" process should:

- **Provide Premium Credits:** Currently enrolled individuals and employers would receive premium credits toward their payments.
- **Provide reasonable timing:** For rebates given directly to individuals, premium credits should be issued within four months after the MLR report is submitted
- **For all markets:** If the amount is less than 2% of the annual premium costs or less than \$100 per enrollee, premium credits would not be provided. Instead, an aggregate contribution to the state high risk pool or risk adjustment mechanism would occur.

Rationale: These suggestions are based on states already requiring rebates – where many use premium credits as an administratively efficient way to issue rebates. Issuing rebates to individual members is administratively costly, as insurers must locate former members that have since dropped coverage and changed location as well as perform the administratively costly "cutting of checks." If rebates for small amounts are required to be issued, the administrative cost will exceed the value of the checks to consumers. This would have the paradoxical impact of increasing administrative costs and premiums to consumers. Providing this aggregate rebate amount to a state entity – such as a high risk pool or risk adjustment mechanism – would benefit all consumers in the market, be administratively efficient, and still act as a "penalty" to insurers that would encourage compliance with the MLR rules.

Recommendation #9: Preemption

Federal Minimum Loss Ratio reporting and rebate rules should preempt state minimum loss ratio rules

Rationale: PPACA minimum loss ratio rules are part of the overall HIPAA framework that includes a preemption if state laws prevent the application of the federal law. As a practical matter, if states have different MLR formulas and rebate rules these would conflict with federal rules. Insurers can only rebate a dollar once...you cannot rebate the same dollar twice. In addition, conflicting state MLR rules would create unnecessary administrative costs and increase consumer premiums.

¹ Phillips, David P.; Christenfeld, Nicholas; Glynn, Laura M. Increase in US Medication-Error Deaths between 1983 and 1993. *Lancet*. 351:643–644, 1998.