



January 31, 2011

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

RE: Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act; Interim Final Rule (45 FR 74864-74934)

Dear Director:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to comment on the interim final rule (IFR) published in the *Federal Register* on December 1, 2010 relating to the Medical Loss Ratio in the Patient Protection and Affordable Care Act.

ACHP is a national leadership organization representing community-based and regional health issuers and provider organizations that collectively provide health care and coverage for approximately 18 million Americans. Our members are not-for-profit health plans or subsidiaries of not-for-profit health systems; most cover substantial numbers of Medicare Advantage enrollees. Member plans share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality.

ACHP appreciates the work that the Department of Health and Human Services has done to implement provisions of the Affordable Care Act (ACA) to date. The ACA requires issuers to meet a Medical Loss Ratio (MLR) of 85 percent in the large group market and 80 percent in the small group and individual markets. ACHP agrees that health plans should seek to return the highest possible percentage of the premium dollar to enrollees for medical services, consistent with efficient administration, investments in high quality care, and fiduciary responsibility. ACHP was pleased to participate in many conference calls sponsored by the NAIC on MLR and premium rebate standards and appreciated the opportunity to submit and discuss our recommendations. The NAIC process contributed substantially toward building a consensus around recommendations that took into account the perspectives of many different stakeholders.

ACHP has identified a number of issues in the proposed regulation that we urge the Department to reconsider. These are presented in order of section number in the IFR:

Reimbursement for Clinical Services Provided to Enrollees (Capitation) – Section 158.140

The references in this section to capitation and what appears to be an attempt in Sec. 158.140(b)(3)(iii) to separate medical and administrative components are confusing and of significant

MAKING HEALTH CARE BETTER

concern to ACHP members that operate through integrated delivery models or through networks of providers under contract. The language as written could present a significant obstacle to capitated arrangements, which would be contrary to the goals of the ACA to promote delivery system reforms and affordable coverage options.

This language is a change from the NAIC recommendation which reflects existing statutory accounting rules. The NAIC model rules (Model MLR Regulation, pp. 190-39, 190-40) classify all payments to providers for professional medical services, whether by capitation or fee-for-service, as a medical expense. In Sec. 158.140(b)(3)(iii), on adjustments that may not be included in incurred claims, the phrase “including amounts paid to a provider” seems to limit provider medical expenses to compensation only for covered services provided to an enrollee. This language suggests that providers, whether capitated or fee-for-service, would have to separate out all of their costs of doing business from their medical costs – a requirement that would be unprecedented and extremely burdensome. Statutory accounting rules do not require insurers to account for providers’ administrative costs. ACHP urges the Department to return to the language that NAIC had submitted on this issue.

Activities that Improve Health Care Quality – Section 158.150

ACHP believes that the definition of quality improvement activities developed by NAIC and incorporated in the IFR struck a reasonable balance that recognizes the range of quality initiatives undertaken by our member plans. However, below we note several areas where we believe changes in the IFR are warranted. Because Congress provided minimal guidance on this requirement and there is little regulatory experience to serve as precedent for this new category, we encourage HHS to view the quality improvement definition and its applicability as evolving over time. ACHP suggests that the Department establish a consultative process in the near future that permits frequent updates of the kinds of activities that can be included under the quality improvement definition, as new approaches to improving the quality of care are developed.

Conversion to ICD-10 Diagnosis Codes - Section 158.150(c)(6)

ACHP recommends that costs for the required conversion to ICD-10 diagnosis codes be recognized as an activity that improves the quality of care. In other rulemaking, the Department clearly saw the quality implications of the new codes: in its final rule on ICD-10 conversion, HHS noted repeatedly the potential of the expanded codes to improve quality. For example, the rule states: “ICD-10-CM and ICD-10-PCS provide specific diagnosis and treatment information that can improve quality measurements and patient safety.” The rule also notes that use of ICD-10, “with its greater detail and granularity, will greatly enhance our capability to measure quality outcomes.” Required use of ICD-10 codes by January 1, 2012 for Medicare Advantage plans particularly imposes a substantial new expense on these organizations. Consistent with the earlier rulemaking, the Department should allow expenses for conversion to ICD-10 to be recognized as quality improvement activities for purposes of the MLR calculation.

Utilization Review - Section 158.150(c)(7)

The distinction between activities that are cost-saving and those that improve quality is not a clear one; many observers have noted that higher quality care can lead to a reduction in expenses. Accordingly, ACHP believes that the Department has erred in not recognizing utilization review (UR) expenses under the definition of activities that improve quality. In conducting UR, health plans seek to assure that services are safe, based upon best practices, and are effective. Plans use UR to

monitor the appropriateness of a single patient's care and also to monitor practice patterns and reduce unwarranted variations in practice – an activity that has important implications for quality of care. ACHP requests that the Department reconsider this issue and recognize UR as a quality improvement expense.

Provider Credentialing - Section 158.150(c)(10)

One of the hallmarks of the approach that ACHP member plans take to delivering high quality and efficient care is to carefully choose providers for their networks and work closely with those providers to manage the care of patients. Provider credentialing is therefore an important tool for improving the quality of care, and is recognized by the National Committee for Quality Assurance (NCQA) as one of six areas in which health plans are evaluated for accreditation. The NCQA notes that credentialing standards encourage “continuous enhancement of a plan's quality and value.” ACHP recommends that the Department recognize expenses related to provider credentialing under the definition of quality improvement activities.

Patient Incentive Payments - Section 158.150(b)(2)(iv)(A)(5)

This paragraph allows patient wellness rewards, incentives, or bonuses to be reported as quality improvement activities for the group market. Examples include an incentive payment to individuals for immunizations, physical exams, and completing a health risk assessment. NCQA recognizes these activities as contributing to quality improvement in its accreditation standards related to encouraging member health. ACHP believes these incentive payments are equally useful in the individual market and can be an important factor in improving the quality of care and health outcomes. We recommend that the Department extend to the individual market its recognition of patient incentive payments under the definition of quality improvement activities.

Community Benefit Expenses - Section 158.162(b)(1)(vii)

As not-for-profit plans or subsidiaries of not-for-profit systems, ACHP member organizations incur significant expenses for community benefit activities. These typically involve such activities as cancer screening, immunizations, and a wide range of health education programs for the community. Investment in community benefit activities is required under federal law to maintain tax-exempt status.

Recognizing that issuers that do not have tax-exempt status also provide community benefit activities, ACHP had suggested to the NAIC that all issuers be allowed to deduct the full amount of those expenses from premium revenue in the MLR denominator. The Commissioners, however, decided that the deduction for community benefit should be allowed for tax-exempt plans only, in light of the fact that the law provided for other issuers to be able to deduct taxes in the denominator. The Department has adopted the NAIC recommendation in this area.

ACHP appreciates that the Department recognizes that tax-exempt plans would be put at a disadvantage if required expenditures for community benefit activities are not deducted from premium revenue in the MLR denominator, similarly to the deduction for taxes. The proposed rule allows tax-exempt health plans to deduct community benefit expenditures up to the level of the state premium tax that applies to for-profit issuers. The Department has raised the question of whether this proposal would serve as a disincentive for tax-exempt plans to make community benefit investments. We agree that the MLR rule should not inhibit the commitments that health plans make to community benefit. As written, the proposed rule would lead to uneven application across the country, as the

level of these state premium taxes varies (sometimes even within a state) and some states do not impose premium taxes. As an alternative, ACHP recommends that, in Sec. 158.162(b)(1)(vii)(C), the Department allow tax-exempt plans to deduct their community benefit expenses up to a flat percentage of premium, applicable in all states. We believe that allowing deductible expenditures of no more than 5 percent of premium would be an appropriate level to minimize disincentives for plans to undertake community benefit activities.

A related concern is that Sec. 158.162(c) of the IFR requires tax-exempt health plans to report community benefit expenditures “but not to exceed the amount of the taxes they would otherwise be required to pay.” This requirement raises two concerns. First, operating income is the product of numerous credits and adjustments, so it is extremely difficult to estimate taxes that would have been required but for tax-exempt status. NAIC recognized this difficulty in its deliberations. Second, a calculation of taxes that would otherwise be required of tax-exempt plans is not used elsewhere in the IFR, so there is no reason to request its reporting; we recommend that you delete Sec. 158.162(c). In Section 158.162(b)(1)(vii), providing for reporting community benefit expenditures that will be used in the MLR calculation, the current IFR allows tax-exempt plans to deduct community benefit expenses up to premium tax rates that apply to for-profit issuers (an issue we address above). Only the *balance* of community benefit expenses not reported under Section 158.162(b)(1)(vii) would be reported as administrative expenses under Sec. 158.160(b)(2)(vi). We suggest that this section would be clearer and more consistent with Sec. 158.162(b)(1)(vii) if it is modified to expressly include only those community benefit expenditures that cannot be deducted from premiums.

Rebate Payments - Section 158.242

Under the IFR, rebates are required to be paid to individuals in the individual market. In the group market, rebates must be made to individual enrollees as well, but the issuer may arrange with group policyholders to distribute the rebate to enrollees on behalf of the issuer. However, the issuer remains liable for making sure that the rebates are received by those enrollees. ACHP believes that this is a potentially burdensome and costly provision that should be changed. In many cases, the issuer does not know the breakdown of premium paid between employer and employee, or changes in those percentages over time.

We recommend that the issuer should be responsible for making the rebate to the group policyholder, and that the latter should then have responsibility to distribute appropriate amounts to individuals in the group. This approach reflects the fact that the contractual relationship is between the issuer and the group, not the issuer and enrollees. Also, the group policyholder maintains complete information on enrollees, including addresses and percentage of premium paid, and therefore is in the better position administratively to make individual rebate payments. ACHP recommends that the language be changed so that the responsibility of the issuer is limited to making the correct amount of rebate payments to the group policyholder.

Penalties - Section 158.606

Using discretion granted in the statute, the Department has proposed penalties for violations of the MLR reporting and rebate requirements. Penalties may be up to \$100 for each day, for each responsible entity, for each individual affected by the violation. These are potentially very high penalties, and the IFR does not attempt to lay out a penalty structure that would match sanctions to the level of violation. However, the IFR lists several mitigating circumstances in Section 158.608 that would reduce the amount of a penalty. ACHP appreciates the inclusion of these mitigating

factors and suggests that the Department also recognize “good faith” efforts to comply, in a manner similar to that in which good faith efforts were recognized in the IFR on internal claims review and external appeals.

Conflicts between the IFR and State Law and Financial Accounting Principles

Finally, and as a matter that cuts across provisions of the IFR, ACHP seeks clarification on the hierarchy of requirements when allocating expenses and calculating rebates, where there may be conflicting provisions with either accounting rules or state law. Current FASB/SSAP principles appear to conflict with the requirements provided by the regulation, in large part due to the fact that such rules have not yet been brought into conformance with the regulation. For example, SSAP No. 85 identifies case management services as a cost containment expense that would normally be carried in the denominator of the medical loss ratio. The IFR, however, considers case management to be a quality improvement activity and carried in the numerator. This implies that health plans would consider case management as a quality improvement expense only for purposes of the MLR, but would not consider such an expense for general financial reporting purposes – with the unintended consequence of adding a confusing element between tracking case management for MLR purposes and tracking for financial reporting. As stated above in this letter, we applaud your proposal to consider case management a quality improvement expense for the MLR. We also recommend that where there are conflicting requirements, you will clarify which rules take precedence until the FASB and SSAP principles are modified.

In addition, some federal requirements conflict with state requirements. The general rule is that when a federal financial requirement conflicts with a state requirement for reporting financial information, the state requirement controls. However, clarification is needed on the extent to which the state requirement controls. For example, New York State currently imposes an 82 percent MLR on certain products; under the IFR, the state’s requirement will supersede the federal requirement. However, New York State also has varying definitions, such as group size and tax treatment, that suggest that a separate method of tracking the MLR ratio would be necessary. We suggest that a transition period be allowed that would provide the opportunity for conformance between federal and state definitions and avoid placing an administrative burden on plans that would otherwise have to follow two types of MLR methodologies.

Thank you for considering ACHP’s views on this important regulation. Please let us know if we can provide additional information or answer any questions.

Sincerely,



Patricia P. Smith
President and CEO