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January 26, 2010

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

Re: **OCIO-9998-IFC**

Dear Sir or Madam:

National Patient Advocate Foundation (NPAF) would like to thank you for the opportunity to comment on the Interim Final Rule with Comment (IFC) entitled "Health Insurance Issuers Implementing Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act" (ACA), which was published in the *Federal Register* on December 1, 2010.¹ NPAF is a non-profit organization dedicated to improving access to healthcare services through both federal and state policy reform. Our mission is to be the voice for patients who have sought care after a diagnosis of a chronic, debilitating or life-threatening illness. The advocacy activities of NPAF are informed and influenced by the experience of patients who receive direct, sustained case management services from our companion organization, Patient Advocate Foundation (PAF). In fiscal year 2009 (July 1, 2009 – June 30, 2010), PAF resolved 64,188 patient cases and received more than four million additional inquires from patients nationally.

We have organized our comments by topic to facilitate review.

Mini-Med Plans

The IFC allows "mini-med" plans – policies that offer a total of \$250,000 or less in annual benefits – to apply a methodological adjustment to their reported experience when they calculate their medical loss ratio (MLR) for 2011. The accommodation will allow mini-med plans that spend only 40-42.5% of premiums on healthcare-related expenses to achieve compliance with the MLR requirements under ACA and thereby continue to operate next year. The expectation is that the permitted adjustment will be sufficient to cover the higher percentage of administrative cost incurred by such plans due to higher enrollee turnover, lower claims volume and lower annual investments in quality improvement initiatives. Impliedly, this or an amended adjustment will be available to mini-med plans until January 1, 2014 when insurance plans other than individual plans with grandfathered status will be required by ACA to offer essential health benefits under policies with no annual limits.

¹ 75 Fed. Reg. 74863 (Dec. 1, 2010).

We understand the Office of Consumer Information and Insurance Oversight (OCIIO) exercised its discretion to include the mini-med adjustment provision in the IFC because it was “concerned about the possibility of the over one million individuals who have coverage through mini-med plans losing that coverage.”² For the same reason, OCIIO previously promulgated another IFC³ and subsequently issued guidance⁴ setting forth a process for mini-med plans to apply for a waiver of the ACA-mandated restrictions on annual limits for plan years beginning on or after September 23, 2010 and before September 23, 2011. That IFC also makes it clear that no such waivers will be extended beyond January 1, 2014 when annual limits on essential health benefits will no longer be permitted except in the case of grandfathered individual market policies.

Based on the experiences of PAF case managers called upon to assist enrollees in mini-med plans over the years, we submit that for mini-med enrollees diagnosed with catastrophic illnesses, OCIIO’s concern about lost coverage is misplaced. Coverage under a mini-med plan – many of which have annual coverage limits well below \$250,000 and sometimes as low as \$10,000 – eliminates an individual’s ability to access more robust insurance coverage through programs such as Medicaid or state programs specific to individuals with particular diseases. Just as importantly, many charity care programs, such as pharmaceutical manufacturers’ patient assistance programs or premium/cost-sharing assistance programs operated by a variety of foundations and patient advocate groups, are available only to uninsured individuals. More often than not, it has been the experience of PAF case managers called upon to help individuals covered by mini-med plans that such grossly inadequate coverage is worse than no coverage at all when a catastrophic illness strikes. Despite the fact that coverage under the mini-med plan is insufficient to permit access to needed care, that coverage will serve to eliminate or, at best, greatly complicate, access to safety-net programs available to the uninsured.

NPAF appreciates OCIIO’s decision to require mini-med plans operating under waivers and MLR methodological adjustments to notify consumers that the plans offer limited benefits and/or do not cover certain serious health problems.⁵ PAF case managers report that many individuals covered by mini-med plans who contact them about access problems mistakenly believe they have comprehensive health insurance coverage. We also applaud the requirement that plan

² *Id.* at 74872.

³ 75 *Fed. Reg.* 37188 (June 28, 2010).

⁴ OCIIO 2010 – 1: Process for Obtaining Waivers of the Annual Limits Requirements of PHS Act Section 2711 (Sept. 3, 2010), available at http://www.hhs.gov/ociio/regulations/patient/ociio_2010-1_20100903_508.pdf; OCIIO 2010 – 1A: Supplemental Guidance (Nov. 5, 2010), available at http://www.hhs.gov/ociio/regulations/annual_limits_waiver_guidance.pdf.

⁵ OCIIO 2010 – 1B: Supplemental Guidance (Dec. 9, 2010), available at http://www.healthcare.gov/center/regulations/guidance_limited_benefit_2nd_supp_bulletin_120910.pdf.

notices direct consumers to a Department of Health and Human Services (HHS) website where they can get more information about health insurance coverage options. We agree with Senator Rockefeller that the new transparency requirements are “a small but important step forward for consumers.”⁶ We would like to see OCIO take a bigger step in 2012 by restricting or, better still, eliminating the availability of mini-med plans, particularly those that have annual limits well below the \$250,000 level that defines the upper boundary of the mini-med concept.

Expatriate Plans

NPAF is much less concerned about OCIO’s decision to apply the methodological adjustment for mini-med plans to expatriate plans. We agree that these plans are likely to incur a significantly higher percentage of spending on administrative cost even if they offer comprehensive health benefits. It also has been PAF’s experience that expatriate policies tend to provide more robust coverage than is the case with the mini-med plans discussed above – plans that typically are offered to lower wage U.S. employees of domestic companies. As a result, expatriate plans have not posed the same barriers to healthcare access for their enrollees. Accordingly, in the context of expatriate plans, the IFC’s accommodation seems to us to be one necessitated by a unique administrative cost situation and not an accommodation that perpetuates the issuance of health insurance policies that afford substandard coverage and provide consumers only with the illusion of insurance protection.

Calculation of the Medical Loss Ratio

NPAF applauds OCIO’s work with the National Association of Insurance Commissioners (NAIC) to develop an MLR calculation methodology that carefully and thoughtfully balances the diverse interests of consumers, providers and insurers. That diligence underlies the generally warm reception the rule has received in public comments since its publication.⁷

We believe the IFC will help ensure that consumers get value for their premium dollar by prohibiting insurers from counting administrative expenses as medical losses and thereby inflating the MLR. We are comfortable with the compromise decision to allow the deduction from premium revenues of licensing fees and taxes on premium revenues but not taxes on investment earnings when the MLR is calculated by dividing premium revenue into sum of claims expenditures and quality improvement expenditures. We are particularly pleased the

⁶ *New Guidance on “Mini-Med” Plans Requires Greater Disclosure About Benefit Limits*, BNA’s Health Care Daily Report (Dec. 10, 2010).

⁷ *See e.g., HHS Issues Medical Loss Ratio Rule; No Changes from NAIC Recommendations*, BNA’s Health Care Daily (Nov. 23, 2010); *MLR Rule Stops Short of Waiver for Mini-Meds, Hews Closely to Draft*, Inside CMS (Nov. 25, 2010); *HHS spells out final medical-loss ratio rules*, amednews.com (Dec. 6, 2010).

regulations focus on evidence-based medicine, widely accepted best practices, recognized authoritative guidelines and measurable outcomes in the definition of quality improvement initiatives that may be aggregated with health spending in the calculation of the MLR. NPAF also appreciates the inclusion of spending on health information technology under the quality improvement rubric since we firmly believe electronic health records show significant potential for reducing errors and allowing the type of data-mining that should facilitate more rapid development of clinically sound evidence-based treatment patterns. We like the criteria developed to characterize quality improvement programs suitable for inclusion in the MLR calculation and believe they should provide sufficient guidance to carriers without stifling quality improvement program innovations.

NPAF strongly supports the decision to reject requests from the insurance industry to aggregate the medical loss ratios of their plans on a nationwide basis. Permitting that approach would have let issuers offset high-quality plans sold in one region with lower-quality plans available in another region and would have obscured information about insurance value that is essential to consumers who must purchase insurance products in state-specific markets. Limiting aggregation to the state level is consistent with the role that states play in the regulation of the insurance industry generally and with the enhanced role they will play in establishing and overseeing the exchanges that will be central to the operation of the commercial insurance industry under ACA. State level aggregation also will lead to the publication of MLR data that will be geographically relevant to consumers.

We would like to see OCIO do more to improve the informational value of the MLR data that will be available to consumers by amending the regulations applicable to plans in 2012 and beyond to eliminate aggregation across various plan types (*e.g.*, indemnity, PPOs, HMOs, high-deductible plans) and market sectors (*i.e.*, large group, small group and individual markets) for those plans that are large enough to allow statistically valid calculations within a given plan type and/or market sector. We appreciate that aggregation is essential in certain instances to allow the calculation of statistically reliable MLRs and to reflect the pooling of risks. We do not want to unbundle MLR calculations to the point where consumers would be at risk of making insurance product purchasing decisions based on statistically unreliable data. Nonetheless, we do not agree that statewide cross-product/cross-sector aggregation should be permitted merely to reduce the reporting burden on insurers when specific plans or the totality of plans serving a market sector are large enough (>75,000 lives) to generate meaningful MLR data without cross-plan or cross-sector aggregation.

Rebates to Compensate for Low Medical Loss Ratios

Because the MLR regulation is ultimately about ensuring consumers obtain value in the insurance market, the IFC requires insurance issuers to provide rebates to their customers if achieved MLRs after credibility adjustments are less than the required MLR of 80% in the small group and individual markets and 85% in the large group market. We understand the need for credibility adjustments to address the effects of random variations in claims histories in insurance plans of different sizes. We also recognize that such adjustments will eliminate some refunds that would otherwise be returned to consumers. We are satisfied with the effort that OCIIO, NAIC and the independent actuarial consultants retained to assist with the development of the MLR regulations put into establishing the credibility adjustments set forth in the IFC. We are not, however, in a position to dispute or to endorse the substantive appropriateness of the specific adjustments adopted.

The IFC permits MLR rebates to be paid in the form of premium credits or lump sum payments at the discretion of the insurer unless the entity due a rebate is no longer enrolled in the issuer's plan. In those situations, a lump sum refund is necessary. NPAF appreciates the need to control to the extent possible the cost of processing rebate payments and we consistently endorse the use of electronic transactions as one way to do so. Accordingly, we are pleased to see that insurers making rebate payments also will be allowed to rebate consumers that paid by credit or debit card by making as a reimbursement to the same account.

Because we believe in limiting costs that do not provide consumer value, we acknowledge the logic of foregoing rebates that are of a *de minimus* amount. We are comfortable with OCIIO's decision to define rebates under \$5 per enrollee or subscriber covered by a policy as *de minimus*. We agree however that, in the aggregate, the total of *de minimus* rebates could be quite substantial. We are pleased the IFC does not permit an insurer to retain such rebates but rather mandates their distribution in equal amounts to all then-current enrollees who receive a premium credit.

When MLR rebates are due on group insurance policies, the IFC allows an issuer to enter into an agreement with the group policyholder under which the policyholder will distribute the rebates to itself and the individual enrollees in the group plan on a pro rata basis based on the amounts each contributed toward the premium. The IFC makes the issuer responsible for ensuring that group plan enrollees are appropriately paid and for maintaining records received from the group policyholder demonstrating the rebates were accurately distributed. NPAF applauds the IFC's recognition of the fact that individuals participating in group insurance plans frequently pay a portion of the premium and therefore deserve a proportional amount of any MLR rebate.

We understand that a group policyholder often will be in a better position than an insurer to accurately and efficiently distribute MLR rebates to group plan enrollees. We recognize that, given the role of states in insurance regulation, much of the necessary oversight of the MLR rebate process will have to rest at the state level. Nonetheless, we are concerned about a possible lack of consumer transparency associated with the MLR rebate process, particularly in the context of group policies, under the IFC. We recognize the IFC requires issuers to provide each enrollee who receives a rebate with a notice explaining the MLR concept and setting forth the particulars of the MLR rebate process as it relates to the issuer's circumstances. We question the adequacy of this notice requirement in the context of rebates due to enrollees in group health plans if the issuer is allowed to rely upon the group policyholder to distribute the notice as well as the rebate. Perhaps it would be prudent to require a discussion of the MLR requirements and the potential for MLR rebates in the Summary Plan Descriptions that must be furnished to enrollees in group health plans under ERISA. We also would favor requiring issuers to obtain enrollee lists from group policyholders and send the required notice about a MLR rebate directly to individuals covered under affected plans to alert them to expect receipt of a pro rata portion of the rebate from their employer, union or other group policyholder if they contributed toward the group plan premium. We see such a notice as crucial to protecting consumers from a group policyholder that decides to inappropriately retain the enrollees' share of a MLR rebate.

NPAF also is concerned about the adequacy of oversight of policyholders called upon to distribute rebates to plan enrollees. We encourage OCIIO to issue guidance to insurance issuers clarifying the contractual terms and oversight procedures that they should put in place to monitor group policyholders that have agreed to facilitate the distribution of a portion of an MLR rebate to plan enrollees. We would envision such a guidance including model contract language. We also would like to see state insurance departments commit to audit the adequacy of issuer oversight of their policyholder partners regarding the pay out of rebates to plan enrollees.

NPAF urges OCIIO to create a process that consumers living in any jurisdiction and covered under any plan type could use to raise concerns and get answers to questions about rebates paid or due to them under the MLR regulations. A good first step would be the establishment of an HHS website site where consumer inquiries and complaints could be registered and responded to in the form of Frequently Asked Questions and, when appropriate, automatically distributed to the proper state insurance department for follow up. Summary Plan Descriptions and issuer notices about pending MLR rebates could both be used to publicize such a web tool and its access address.

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We thank you for the opportunity to comment. We would be pleased to respond to any questions about our recommendations regarding the MLR regulations and their implementation.

Respectfully submitted,

A handwritten signature in cursive script, appearing to read "Nancy Davenport-Ennis".

Nancy Davenport-Ennis
Chief Executive Officer and President