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United States Senate
COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION
WASHINGTON, DC 20510–6125
WEB SITE: http://commerce.senate.gov

May 7, 2010

Commissioner Jane L. Cline
President
National Association of
Insurance Commissioners
2301 McGee Street
Suite 800
Kansas City, MO 64108-2662

Dear Commissioner Cline:

I am writing to share my thoughts with you about the implementation of the new law establishing minimum medical loss ratios in the commercial health insurance market. I am extremely concerned that the health insurance industry is mounting an all-out effort to weaken this important consumer protection provision included in the health care reform legislation President Obama signed into law in March. I appreciate the complexities you face as you work to implement the medical loss ratio provision over the next few months, but I also urge you to keep in mind the very simple principle underlying this provision – most of consumers' health insurance premiums dollars should be going to pay for patient care, not for insurers' administrative costs and profits.

There is no doubt that the health insurance industry has now shifted its focus from opposing health care reform to influencing how the new law will be implemented. The new minimum medical loss provisions, which take effect on January 1, 2011, are currently a focus of the health insurance industry's lobbying efforts. The authors of an April 27, 2010, Barclays Capital health care market analysis explained the reason for this focus very clearly:

> As we have spoken about on numerous occasions, **we believe that the definition of Medical Loss Ratios for the purpose of health care reform will be one of the most important events for the year for managed care stocks** [bold in original].[1]

While I understand that regulators need to consider the financial implications of this new law for health insurance companies, I also want to remind you (in bold type) **that the implementation of these new minimum medical loss ratios will be one of the most important events for consumers and small businesses before health insurance exchanges start operating in 2014.**

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[1] Joshua R. Raskin, Barclay's Capital Equity Research, *Health Care – Managed Care Industry Overview: First Sign of MLR Language Positive* (April 27, 2010).

Data analyzed by the Senate Commerce Committee staff and others show that many insurers already meet the newly established medical loss ratio requirements in the group and individual markets that go into effect next January. But the data also show that in some markets and some product lines, insurers are not yet meeting the new requirements.[2] The purpose of the legislation is to provide health insurance companies falling below the requirements a new incentive to spend more of every premium dollar on patient care and the quality of that care. To the extent insurers try to invent ways to "game" the minimum medical loss ratio requirement without changing their actual business practices, they are defeating the purpose of the medical loss ratio provision.

Based on media reports and comments that have been filed with the National Association of Insurance Commissioners (NAIC), it is clear that health insurance companies are focusing on two key areas in medical loss ratio implementation: 1) they are proposing that medical loss ratio information be aggregated in a way that conceals important variations in the health insurance market, which would make it easier for insurers to meet the new minimum medical loss ratios of 80% in the individual and small group markets, and 85% in the large group market, and 2) they are eager to classify as many expenses as possible as medical or "quality-improving" expenses, which would also make it easier for them to meet the new minimum medical loss ratios and avoid paying rebates to their policyholders.

In this letter, I will address both of these issues and present health insurance company financial information that I think will assist you in the implementation process. I believe that medical loss ratio information should be aggregated at a level that will be useful for consumers shopping for individual or group coverage in a specific market area. I also believe that health insurance companies must be able to prove that a particular expense actually improves health care quality before insurers can count it as a medical expense.

1. Minimum Medical Loss Ratios Must Be Aggregated and Reported in a Way that Benefits Consumers

For-profit health insurers routinely report company-wide medical loss ratio information to their investors in their quarterly financial reports. For investors, a stable or declining company-wide medical loss ratio means that a company is controlling its costs and is more likely to be profitable in upcoming quarters. For regulators, company-wide medical loss ratios can provide useful information about a company's overall financial condition and its ability to meet its future claims obligations.

As I have pointed out on several occasions, however, medical loss ratios vary widely by insurance product type and by geographic location. As a result of this variation, company-wide

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[2] Senate Committee on Commerce, Science, and Transportation, *Staff Report on Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers* (April 15, 2010) (online at http://commerce.senate.gov/public/?a=Files.Serve&File_id=be0fd052-4ca6-4c12-9fb1-a5e4a09c0667).

medical loss ratio information has little or no value for a consumer shopping for health insurance in the individual or group markets.[3]

For example, WellPoint told its investors that, in 2009, its overall commercial medical loss ratio was 82.6%. But as a recent Senate Commerce Committee staff report demonstrated, consumers purchasing WellPoint insurance products in the individual and small group markets experienced medical loss ratios significantly below the company-wide rate (73% and 79%, respectively).[4]

There was not only a great deal of variation between different market segments. There was also great variation within each of the market segments. A table included in the Commerce Committee staff report shows that in 2009, WellPoint customers purchasing individual or small group policies from different WellPoint subsidiaries in different states were subject to widely varying medical loss ratios.

2009 Medical Loss Ratios for Selected WellPoint Subsidiaries by Market Segment

	Individual Segment	Small Group Segment	Large Group Segment
Anthem Health Plans of NH	62.9%	87.9%	88.4%
Anthem Health Plans of VA	72.1%	66.6%	79.4%
Rocky Mountain Hospital & Medical	74.1%	79.9%	83.1%
Blue Cross Blue Shield of GA	75.5%	78.0%	86.0%
Anthem Health Plans of KY	79.4%	80.9%	82.0%
Anthem Health Plans of ME	95.2%	86.9%	89.5%

Source: 2009 NAIC Accident & Health Policy Exhibit Filings

For example, WellPoint customers purchasing individual health insurance policies in New Hampshire were subject to a very low medical loss ratio (62.9%), under which WellPoint used more than one-third of its customers' premium dollars for administration and profits. Across the border in Maine, however, consumers purchasing individual insurance from WellPoint enjoyed a much higher medical loss ratio of 95.2%.

The Commerce Committee staff report also noted similar variations in the small and large group markets. While small employers purchasing group health insurance in Virginia were subject to a medical loss ratio of 66.6%, small business owners in neighboring Kentucky

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[3] *See e.g.,* Letter from Chairman Rockefeller to Mr. H. Edward Hanway, Chairman and CEO of CIGNA (Nov. 2, 2009) (online at: http://commerce.senate.gov/public/index.cfm?p=HearingsandPressReleases&ContentRecord_id=dab514f7-1fc7-496b-a8b8-712987792fa8&ContentType_id=77eb43da-aa94-497d-a73f-5c951ff72372&Group_id=165806cd-d931-4605-aa86-7fafc5fd3536&MonthDisplay=11&YearDisplay=2009).

[4] *Supra*, note 2.

experienced a medical loss ratio (80.9%) that already exceeds the minimum loss ratio level set in the health reform law.

This information clearly shows that medical loss ratios significantly vary according to where consumers live and in which market segment they are shopping for health insurance. Aggregating medical loss ratio data at the national or multi-state levels therefore will not capture this diversity of consumer experience and would potentially deprive consumers in states such as New Hampshire or Virginia of the new law's benefits. For example, aggregating medical loss ratios at high levels would make it difficult for regulators to identify harmed consumers such as the New Hampshire individuals or Virginia small businesses, who are entitled to rebates because they are subject to medical loss ratios that fall below the minimums set in the new law.

Likewise, aggregating medical loss ratio between market segments (such as combining individual and small group medical loss ratios) fails to capture the significant differences between insurance coverage offered in the different market segments.

I therefore recommend that you require insurers to report their medical loss ratio information at a level of aggregation that would allow consumers living in a particular State or other definable geographic region to determine how insurers are spending their health care premium dollars.[5] Aggregating this information at too high a level will present consumers with misleading averages of multiple, disparate markets. For the same reason, I also recommend that insurers provide separate medical loss ratio information for the individual, small and large group market segments.

2. *Insurers Must Demonstrate that their Quality-Improving Expenditures Are Actually Benefiting Consumers*

Health insurance companies and insurance regulators have generally defined the medical loss ratio as the value of the claims an insurer pays in a certain period ("incurred claims") divided by the total value of the premiums the insurer collects during the period. The medical loss ratio provision in the new health care law makes an important change to this definition by creating a new accounting category for expenditures on "activities that improve health care quality."[6] These quality-improving expenditures will not be considered as administrative expenses, but as medical expenses that can help insurers attain the new minimum medical loss ratios of 80% in the individual and small group markets, and 85% in the large group market.

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[5] In situations where health insurance companies do not have sufficient premium volumes to develop statistically reliable medical loss ratio data for a particular State, the Secretary and/or State regulators should have the discretion to determine the level of aggregation that will provide credible loss experience for consumers.

[6] Sec. 2718(a)(2) of Title XXVII, Part A of the Public Health Service Act, as added by Sec. 10101(a) of Title X of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010).

This new expense category will give health insurance companies whose insurance products fall below the new federally required minimum medical loss ratios a strong financial incentive to reclassify their existing administrative expenses. For example, under the new law, if an insurer collected $100 million in premiums from business owners for small group coverage, and then used $78 million of these premiums paying claims and $22 million on administrative costs and profits, it would be required to rebate $2 million to its policyholders. But if the insurer found a way to reclassify 2% of its administrative expenses as "quality improvement expenses," it would then meet the 80% minimum medical loss ratio for small groups, and would be able to keep the $2 million.

The recent Commerce Committee staff report discussed how insurers are actively reviewing their accounting practices and attempting to shift expenses from the administrative to the medical side. For example, WellPoint has already announced it has started "reclassifying" certain expenses it has traditionally classified as administrative, such as nurse hotlines, disease management, and clinical health policy. By reclassifying these expenses as quality-improvement expenses, WellPoint projected its company-wide 2010 medical loss ratio would increase by 1.7%. This "accounting reclassification" means that the company has converted more than a half a billion dollars of 2010 administrative expenses into medical expenses.[7]

The purpose of the "health care quality improvement" category in the medical loss ratio provision was not to provide health insurance companies new opportunities to cook their books. The purpose of the provision was to encourage health insurers to spend money on health care services that have been demonstrated to improve the safety, timeliness, and effectiveness of patient care. This provision and many other similar provisions included in other titles of the new health care reform law reflect President Obama's and the Congress' commitment to improving the quality of health care delivery and ultimately patient health outcomes in the United States.

I appreciate that developing a definition of "activities that improve health care quality" in a period of several months is a difficult task. I also appreciate that insurers are probably bombarding your office with lists of "quality-improving" expenditures they would like you to include in the definition you are currently developing. For these reasons, I recommend that you ground your definition of quality-improving activities in the already existing research on health care quality that the Agency for Healthcare Research and Quality has performed in consultation with non-governmental entities.

If insurers propose that certain types of expenditures, such as "disease management" or "clinical health policy" expenses, be considered quality-improving expenses under the new law, you should require them to substantiate these claims. You should require them to demonstrate that these expenses will improve health care quality, as that term is currently defined and

[7] *Supra*, note 2.

understood by a consensus of the groups that track health care quality indicators and establish health care quality standards.[8]

Once these evidence-based definitions are established, you should also require health insurance companies to consistently apply them to their balance sheets. An insurer should not be able to define an expense as medical one year when it finds itself below the minimum medical loss ratio, but then define it as administrative another year when it is above the minimum. In addition, the definitions should be modified over time as health care quality research provides new information about health care delivery best practices.

As a reference point, you should consider what health insurers are currently spending on so-called "cost containment" expenses. An accounting guidance issued by the NAIC in 2002, known as "SSAP 85," allows health insurers to subtract certain "cost containment expenses" from their claims adjustment expenses, and thereby reduce their reportable administrative expenses. SSAP 85 defines cost containment expenses as expenses that "serve to reduce the number of health care services or the cost of such services."[9] Cost containment expenses include spending on activities such as case management, fraud detection, disease management, and smoking cessation programs.

While some of the activities currently defined as cost containment expenses in SSAP 85 should not be included in the definition of "activities that improve health care quality," health insurers' actual reported cost containment expenses provide a useful benchmark. While insurers are telling you what they intend to spend on quality improvement in future years, cost containment expense reports show what portion of every premium dollar insurers are currently investing in improving the efficiency of health care delivery.

Cost containment data reported to NAIC and analyzed by the Senate Commerce Committee staff shows that insurers currently invest only a tiny portion of their premium revenues in cost containment activities. Attached to this letter is a table showing the 2009 cost containment expenses of 113 health insurers that exclusively or almost exclusively sold comprehensive health coverage in the fully insured market.[10] This table shows that these companies spent an average of 1.15% of their premium dollars on cost containment activities.

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[8] A number of commenters to the NAIC have discussed whether certain preventive health services should be defined as quality-improving expenses. These comments do not appear to have considered another new provision in Title I of the health care reform law (Sec. 2713), which requires insurers to pay the full costs of preventive services that have received high ratings from the U.S. Preventive Services Task Force. This new coverage requirement is likely to have the short-term effect of moderately increasing insurers' incurred claims expenses and therefore their medical loss ratios.

[9] NAIC, *SSAP No. 85: Claims Adjustment Expenses, Amendments to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses* (June 10, 2002).

[10] Using NAIC data from the 2009 Health Annual Statement Blank (the "Orange Book"), Committee staff analyzed the cost containment expenses of the 113 health insurance companies writing over 90% of their business in comprehensive major medical, with at least $10 million in earned premiums. The analysis was limited to this group because cost containment expenses are reported on a company-wide, rather than a product-specific, basis. See the table attached to this letter for more information.

For example, the table below shows cost containment data for the 11 UnitedHealth subsidiaries that almost exclusively sold comprehensive health insurance in 2009. All but one of these companies spent less than 1% of their premium dollars on cost containment.

2009 Cost Containment Expenses by Selected UnitedHealth Subsidiaries

	Premiums Collected	Cost Containment Expenses	% Cost Containment of Premiums
Oxford Health Insurance Inc	$4,357,890,632	$9,924,656	0.2%
Optimum Choice Inc	$460,388,489	$2,885,216	0.6%
Neighborhood Health Partnership Inc	$431,571,309	$2,406,816	0.6%
UnitedHealthcare of IL Inc	$80,827,326	$445,012	0.6%
UnitedHealthcare of KY Ltd	$48,995,795	$280,137	0.6%
UnitedHealthcare of TX Inc	$32,417,101	$161,581	0.5%
United Healthcare of LA Inc	$29,185,947	$132,112	0.5%
UnitedHealthcare Ins Co of the River	$68,136,654	$471,191	0.7%
Health Net Insurance Co NY Inc	$726,780,187	$13,975,695	1.9%
Mamsi Life & Health Ins Co	$120,260,636	$641,177	0.5%
Pacificare Life Assurance Co	$184,723,354	$1,285,486	0.7%

Source: NAIC Health ("Orange Book") Filings

Because insurers have strong financial incentives to "MLR shift" as many expenses as possible from the administrative to medical side, I urge you to review with skepticism any insurance industry proposal that would allow insurers to claim that they will spend significantly higher portions of premium dollars on quality improvement in the year 2011 than they are currently spending on cost containment.

For example, Carl McDonald, an Oppenheimer health care market analyst, recently discussed a scenario in which insurers could shift as much as 500 basis points (or 5%) of premium revenues from administrative to medical.[11] Such a shift, which represents a 400% increase over current levels of cost containment spending, clearly suggests insurers are discovering accounting loopholes, rather than actually investing in improving patient care.

Conclusion

During the process of implementation of the medical loss ratio provision, I urge you to keep in mind that it was not written to help health insurers' maximize their profitability over the next three years. The purpose of this provision was to provide consumers in the individual and group markets an assurance that most of their premium dollars would be spent on health care, rather than on administrative costs and profits. I look forward to working with you on this and

[11] 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).

other important consumer protection issues as the new health care reform law is implemented over the next few years.

Sincerely,

John D. Rockefeller IV
Chairman

cc: Kay Bailey Hutchison
Ranking Member