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Submitted Via Federal Rulemaking Portal: http://www.regulations.gov

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

RE: Interim Final Rule for Health Insurance Issuers Implementing Medical Loss Ratio (MLR) requirements Under the Patient Protection and Affordable Care Act

To Whom It May Concern:

The U.S. Chamber of Commerce (the "Chamber") submits these comments in response to the Interim Final Rule for Health Insurance Issuers Implementing Medical Loss Ratio ("MLR") Requirements under the Patient Protection and Affordable Care Act ("Interim Final Rule" or "IFR"), as published in the Federal Register on December 1, 2010.[1] This IFR implements the Medical Loss Ratio requirements for health insurance issuers under the Public Health Service Act's §2718, as added by the Patient Protection and Affordable Care Act ("PPACA").[2]

The Chamber is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. These comments have been developed with the input of member companies with an interest in improving the health care system.

While we understand the statutory and legal constructs within which the implementing IFR must operate, the Chamber continues to have serious overall policy concerns about the imposition of inappropriate medical loss ratios on the health insurance market, in general. The statute's poorly synchronized reforms impose heavy burdens on current coverage offerings now, well before additional insurance markets' coverage becomes available in 2014. Instead of recognizing the need for coordination and transition, the statute imposes undue burdens on fully insured large

[1] Interim Final Rule for Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 74,864-74,934 (December 1, 2010) (to be codified at 45 C.F.R. pts. 158) [hereinafter Medical Loss Ratio IFR].

[2] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1001, 124 Stat. 119 (2010). (Amended by §10101(f)).

group plans and mandates that issuers do more administrative work, for more enrollees, and spend less doing so. The IFR offers little relief, further compounding the Statute's lack of synchronicity by inappropriately and inconsistently categorizing funds spent on medical management and utilization review techniques (while recognized by the Departments as valuable) as administrative, in nature. Our additional concerns remain that the application of this statutory requirement and compliance with this implementing IFR will lead to the disruption of currently available and valued coverage, and the decline of important quality, efficiency, and cost control programs.

Despite our significant concerns with the overall structure and timing of the medical loss ratio requirement as contained in the statute and implemented by IFR, our comments also include suggestions regarding the distribution of the rebate and the audit language.

OVERALL POLICY CONCERNS

Statutory Concerns: Poor Coordination

As enacted, the statute places an exceptional strain on employers, insurers and providers years before other coverage options become available.

1. Undue Burdens on Fully-Insured Large Group Plans

   States have regulated plans offered in the more volatile small group and individual health insurance markets for years, but have rarely extended this regulatory control over plans in the large group markets. Specifically, numerous states in advance of PPACA imposed medical loss ratio and rebate requirements on plans offered in the small group and individual market, while it has been virtually unheard of for states to impose such burdens on plans offered in the large group market. This is because the large group health insurance market functions very well.

   While the statute imposes MLR requirements on "health issuer(s) offering group or individual health insurance coverage,"[3] the IFR appropriately exempts similar large group self-insured plans from this burden.[4] While we believe the IFR is appropriate in making this exemption for self-insured plans, the Chamber believes that fully-insured large group plans should similarly ***not*** be subjected to MLR and rebate requirements. Although the statute is clear, we believe that by exempting self-insured plans from this requirement, the law and its implementing IFR create an unreasonable preference for self-insured plans. This burden, along with many others contained in the law, will make it exceedingly difficult for employers to offer health insurance coverage on a fully insured basis.

   Along with the numerous others contained in the law, this burdensome requirement is imposed on plans before other insurance coverage options are available. Given that expanding insurance coverage is the underlying goal of the reform law, the lack of

[3] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1001(1), 124 Stat. 119 (2010), amended by § 10101(f). "Sec. 2718. Bringing Down the Cost of Health Care Coverage."

[4] Medical Loss Ratio IFR, 75 Fed. Reg. at 74,865.

synchronization and coordination between the new insurance requirements imposed now and the creation of new coverage options in 2014 is counterintuitive. As these requirements are being placed on employers and issuers currently offering coverage to millions of people, they may have the unintended consequences of driving issuers out of the business of offering major medical insurance[5] and forcing many employers[6] to stop offering health care coverage to their employees before other coverage options are available.

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[5] There are five examples of issuers that have pulled out of the business of offering major medical insurance:

- American Family Insurance Co.
  Schoofs, Mark and Johnson, Avery. "Health Overhaul Hits Sales Commissions." The Wall Street Journal. 18 May 2010 (Accessed January 31, 2011).
  http://online.wsj.com/article/SB10001424052748703612804575222291352083452.html
  "This June, American Family Insurance Co., a property and casualty insurer based in Madison, Wis., will hand over the administration of its individual insurance policies to American Enterprise Group Inc., because American Family decided it can't shoulder the administrative costs, said a spokesman."
- Principle Financial Group
  Abelson, Reed. "Citing Law, Company Quits Health Insurance." The New York Times. 10/1/2010 (Accessed January 31, 2011).
  http://www.nytimes.com/2010/10/01/health/policy/01insure.html?scp=1&sq=Citing%20Law,%20Company%20Quits%20Health%20Insurance%20&st=cse
  "The Principal Financial Group announced on Thursday that it planned to stop selling health insurance."
- National Health Insurance Co., Aetna, and John Alden
  Jennings. Trip. "Health insurance companies drop NM policies for individuals, small groups. New Mexico Independent. 10 26 2010 (accessed January 31, 2011)
  http://newmexicoindependent.com/65802/health-insurance-companies-drop-nm-policies-for-individuals-small-groups
  "National Health, Aetna, John Alden, and Principal all have told the state's Division of Insurance that they will no longer write individual or small group plans in New Mexico, according to a Public Regulation Commission spokesman.

[6] Several employers have said that strict application of the law, as enacted, would force them to stop offering coverage.

- Adamy. Janet. "McDonald's May Drop Health Plan." Wall Street Journal. 30/ 9/2010 (accessed January 31, 2011)
  http://online.wsj.com/article/SB10001424052748703431604575522413101063070.html
  McDonald's, in a memo to federal officials, said "it would be economically prohibitive for our carrier to continue offering" the mini-med plan unless it got an exemption from the requirement to spend 80% to 85% of premiums on benefits. Officials said McDonald's would probably have to hit the 85% figure, which applies to larger group plans. Its insurer, BCS Insurance Group of Oak Brook Terrace, Ill., declined to comment.
  "The Big Mac Attack On ObamaCare." Investor's Business Daily. 9 30 2010 (accessed January 31, 2011):
  http://www.investors.com/NewsAndAnalysis/Article/549026/201009301853/The-Big-Mac-Attack-On-ObamaCare.htm
  President Obama promised that under ObamaCare these workers could keep these plans, but McDonald's has told federal regulators in a memo that it would be "economically prohibitive" for its insurance carrier to continue to cover its hourly workers unless it receives a waiver to the ObamaCare requirement that 80% of premiums for such "mini-med" plans be spent on medical care. Other large employers who offer such plans could find themselves in the same dilemma — companies like Home Depot, CVS, Staples and Blockbuster.
- Adamy. Janet. "3M to Change Health-Plan Options for Workers." Wall Street Journal. 4-10-2010 (accessed January 31, 2011)
  http://online.wsj.com/article/SB10001424052748703859204575526953379583836.html
  "In addition, health care reform has made it more difficult for employers like 3M to provide a plan that will remain competitive," the memo said

2. Do More, For More, With Less

   Significant requirements are forcing plans to make substantial administrative changes, provide an extensive array of new notices in multiple forms and languages,[7] and adopt dramatic system and staffing changes,[8] while also mandating that plans extend coverage (with in many cases prescribed benefits[9]) to additional populations.[10] This burden is significant; the timeframe is stringent and often impossible, as the Department has tacitly and laudably recognized by offering necessary enforcement grace periods.[11] However, these obligations on plans to do more administratively for more enrollees are compounded by an additional restriction. In the same timeframe while plans are being forced to make such dramatic changes, the MLR requirements are ruthlessly forcing plans to do additional work, for more enrollees with the use of fewer resources. It is inconceivable that such dramatic changes could be made by any corporation or industry while also being subjected to such economic scrutiny.

   While we recognize the statutory prescriptions, the Chamber both laments and admonishes the lack of transition permitted for plans to comply with these extensive mandated changes. It is both unreasonable to expect, and perverse to require, plans that currently offer coverage to make such fundamental and systemic modifications while also complying with the financial constraints of medical loss ratio requirements and rebate penalties. The agencies will fail consumers if imposing strict Medical Loss Ratios leads to a decline in valued coverage.

[7] New notice requirements include those contained in: (1) the Interim Final Rule implementing the Internal Claims and Appeals and External Review Process which require plans/issuers to provide extensive and excessively detailed notices in three different cases (adverse benefit determinations, final internal adverse benefit determinations, and for final external review decisions) which must be provided in a non-English language based on thresholds of the number of people who are literate in the same non-English language; (2) the Interim Final Rule implementing the Grandfathered Plan Status which require plans to notify enrollees that the plan or coverage believes it has retained grandfathered plan status and provide contact information for questions and complains; (3) the Interim Final Rule implementing Medical Loss Ratio which require plans to issue a notice with any rebate.

[8] New difficult and complex system and staffing changes are required by the Interim Final Rule implementing the Internal Claims and Appeals and External Review Process which require urgent claim determinations to be adjudicated within 24 hours after receipt of the claim. This would require plans to change staffing and workforces to insure that claim review is conducted 24 hours a day, 7 days a week.

[9] Prescribed benefits: non-grandfathered plans are now required to cover preventive services on a first dollar basis.

[10] The law requires plans that offer dependent coverage to extend such coverage to adult children until the age of 26.

[11] Several enforcement grace periods were extended for the requirements articulated in the Interim Final Rule implementing the Internal Claims and Appeals and External Review Processes: The Department of Labor extended an enforcement grace period until July 1, 2011 for some of the notice requirements contained in the Internal Claims and Appeals and External Review Processes Interim Final Rule. For fully insured non-grandfathered plans, plans are permitted to use existing state external review processes in one of the state in which they operate to comply with the new Federal requirements. For self-insured plans, an enforcement safe harbor was created which permits plans that comply with interim measures and states that no enforcement action will be taken during the transition period and failure to contract with 3 independent review organizations will not automatically violate the requirements.

Concerns with the IFR – Inconsistencies

While the Chamber and the Department both appreciate the value of medical management and the need to preserve coverage currently offered, the IFR contains inconsistencies which will undermine these important objectives.

1. Use of Medical Management and Utilization Review
   In addition to the extensive statutory requirements, the regulations implementing the law further exacerbate the problem, by increasing the need for insurers to use medical management and utilization management while also requiring plans to cut their spending on these categories of costs. We believe that medical management and utilization review are critical tools and agree (as the regulations and sub-regulatory guidance have stated) that plans must be permitted to employ these techniques in assessing covered services such as how frequently to offer certain preventive services.[12] This implicit recognition by the Department of the critical value of these techniques further supports re-categorizing these valuable and widely used practices as quality improvement activities. Classifying these laudable initiatives as "administrative" on the part of the insurer who is paying for them, will force plans to abandon them and forgo the very goals that health reform purported to advance.

2. Current Process for Adjustments and Waivers
   The Chamber appreciates the Department's recognition of the problems that the Medical Loss Ratio requirements will create for the individual markets in some states, as well as for certain limited benefit plans. We also understand the Department's trepidation in granting broad categorical exemptions, for fear of overstepping the authority granted by the statute and appearing to grant certain industries special treatment. While we appreciate the efforts to protect currently available coverage, we respectfully request that the Department reconsider its approach. Instead of the current process of issuing temporary exemptions which provide a one-year fix and require quarterly reporting and formal application, we urge the Department to create a unilateral solution which will end the speculation of favoritism and ensure coverage options can continue until 2014 when broader coverage options become available.

DISRUPTION OF CURRENTLY AVAILABLE AND VALUED COVERAGE

Unfavorable competitive advantages will result in fewer coverage options and less choice for consumers and employers. We urge the Department to consider the problems that medical loss ratio requirements will create for many different types of currently available and valued coverage and remember the promise to the American people: "if you like the coverage you have, you can keep it."

In particular, the Chamber is concerned that the MLR and rebate requirements will undermine high deductible plans. High deductible plans have lower premiums, carry less volume of medical costs and also create different incentives for keeping costs down. We remain troubled that these

[12] Affordable Care Act Implementing FAQs, Second Set – Issued October 8, 2010. Question 8. (available at: http://www.hhs.gov/ociio/regulations/implementation_faq.html)

plans will be unduly penalized because of this structure which would lead to further disruption and the loss of valued coverage which many Americans enjoy.

DECLINE OF IMPORTANT QUALITY, EFFICIENCY, AND COST CONTROL PROGRAMS

The Chamber strongly supports programs, whether offered by an insurer or an employer, which modify consumer behaviors to improve health and incentivize activities that will lead to a healthier population, whether medical, fitness, or otherwise. These programs range broadly from health promotion through transparency, education and information, to prevention of chronic disease, to management of conditions to reduce hospitalizations or control outbreaks, etc. Health is improved by programs that educate providers on how to address chronic conditions, programs that support consumers' self-management and which encourage consumers to fill prescriptions and complete care regimens, etc. The umbrella of programs included under the prevention and wellness category should also include efforts to promote patient safety and reduce medical errors, which can lead to much costlier and more serious conditions later. All of these efforts have been demonstrated to lead to overall lower costs for consumers by improving their health and wellbeing, and none of them should be considered "administrative".

The Chamber remains concerned that the MLR requirements as created by the Statute and implemented by the IFR will discourage employer innovation in the areas of care coordination. Wellness and case management programs, quality programs, efficiency and adherence programs, programs to combat fraud and abuse, and programs that drive down premiums are in the best interests of patients and consumers. The way these programs are classified by the IFR creates a perverse incentive for insurance companies to increase spending on medical services, which will only further increase costs for everyone involved. The Chamber supports efforts to reduce health care and health insurance costs, and cautions against forcing insurers to create waste or inefficiency in order to run their businesses.

SPECIFIC CONCERNS

Rebates

The statute places the obligation on the issuer to provide an annual rebate to each enrollee under such coverage.[13] A fair implementation of this provision can be complicated with employer-sponsored health coverage. As the regulations acknowledge,[14] many times the employer contributes significantly if not exclusively to employee premiums. Additional reporting and tracking obligations associated with the issuance and distribution of rebates must be kept to an absolute minimum to limit additional costs to the healthcare system. To do otherwise would directly contravene one of the goals of the law. While we recognize this will be complicated process, situations will vary and it should be permissible for employers to negotiate with the issuer over the responsibility of distribution of rebates.[15] We also ask the Department to clarify, as we believe it intended to, that rebates are not plan assets.

[13] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1001(1), 124 Stat. 119 (2010), amended by § 10101(f). "Sec. 2718. Bringing Down the Cost of Health Care Coverage. (b) Ensuring that consumers receive value for their premium payments."

[14] Medical Loss Ratio IFR, 75 Fed. Reg. at 74,884 and at 74,929 (to be codified at §158.242(b))

[15] Ibid.

Audits

We request that the Department revise the language contained in Subpart E with regard to what is auditable. Overly intrusive language seems to suggest that an employer's records could be audited.[16] Specifically, where the IRF states "each issuer must also allow access and entry to the facilities and records, including computer and other electronic systems of its parent organization, subsidiaries, related entities, contractors, subcontractors agents, or a transferee that pertain to any aspect of the data reported to HHS or to rebate payments calculated and made under this part." We believe that the intent of the IFR was to clarify that other entities performing issuer functions would be auditable. We do not believe that this is intended to extend to employers purchasing coverage via contract from the issuer. The IFR does not include consumers or purchasers in this provision and it would be inappropriate to do so.

Agent broker fees

The Department specifically mentioned the potential impact of the MLR standard on agents and brokers and provided that this impact will be a factor in considering whether a particular individual market would be destabilized. In response to this request for comments on the approach taken in this regulation and on the issues related to agents and brokers during years leading up to 2014, we reiterate our previous support of the importance of agents and brokers. Insurance agents and brokers serve a critical role in the health care marketplace by aiding consumers and employers in determining the health plan that best suits their needs at a premium they can afford. The experience and knowledge of agents and brokers will be especially important in a post-reform health insurance marketplace, as many will be looking for experts who understand the effects of the profound changes.

Fraud and Abuse

Consumers demand that insurers help in efforts to control premium costs, and a key way of doing so is to prevent fraud and abuse. Programs in this area range from investigating billing practices, to prior authorization for some procedures and tests, to funding "secret shoppers" and investigating entities before allowing them to engage in billing, etc. Programs which prevent fraud and abuse improve the quality of care for patients by freeing up funds that would otherwise be wasted, and improve patients' ability to afford health insurance, as well as their financial freedom. We urge the Department to codify that fraud and abuse prevention should not be considered "administrative" spending.

CONCLUSION

We appreciate the opportunity to comment on the Medical Loss Ratio IFR and thank the Department for considering our previous comments in response to the Request for Comments.[17] We are happy to discuss any of our comments informally, or by way of testimony in hearings

[16] Medical Loss Ratio IFR, 75 Fed. Reg. at 74,934 (to be codified at §158.501(a) and (b))

[17] Medical Loss Ratio, Request for Comments Regarding Section 2718 of the Public Health Service Act 75 Fed. Reg. 19,297-19,302 (April 14, 2010) (to be codified at26 C.F.R. pt. 54, 29 C.F.R. pt. 1590 and 45 C.F.R. pts. 146 and 148).

conducted by the Department. We support the general principles of improving health care coverage and access and applaud the Administration's promise to the American people that nothing will require an existing plan to terminate coverage. We look forward to working with you to protect the fundamental goals of health reform that we jointly support.

Sincerely,

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U.S. Chamber of Commerce

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