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To What Extent Did the HHS Fall Short of Adequately Interpreting the Medical Loss Ratio Rule to Address Consumers' Concerns

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I. Introduction

Health experts agree that the U.S. healthcare system is broken and needs significant reforms to overcome "inefficiencies, excessive administrative expenses, inflated prices, poor management and inappropriate care, waste and fraud."[1] As healthcare costs increase[2] and health insurance companies increase profits[3] and CEO compensations,[4] a growing number of Americans are struggling to afford basic necessities and healthcare.[5] Thus, in an effort to find a solution to the American healthcare crisis and to reform the US crumbling healthcare system, on March 23, 2010 President Barack Obama signed into law one of the most significant pieces of legislation in the U.S. healthcare history since the passage of Medicare and Medicaid in 1965 -

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1 National Coalition on Health Care, Health Care Facts: Costs, available at http://nchc.org/sites/default/files/resources/Fact%20Sheet%20-%20Cost.pdf

2 Id. Between 2008 and 2018, the national health expenditures are expected to increase at a 6.2% rate, almost 2% faster than the national GDP, which is expected to increase only 4.1% per year.

3 Emily Walker, *Health Insurers Post Record Profits*, abcnews .com (Feb. 12, 2010), available at http://abcnews.go.com/Health/HealthCare/health-insurers-post-record-profits/story?id=9818699&page=3. In 2009, when America was in the center of a deep economic recession, America's health insurance companies increased their profits by 56 %, with five largest for profit insurers making a combined profit of $12.2 billion, while during the same year 2.7 million Americans lost their private coverage.

4 Donna Rodgers, *Total Compensation of CEOs at Health Insurance Companies*, About.com, available at http://financialservices.about.com/od/CompRelatedFA/i/Total-Compensation-Of-Ceos-At-Health-Insurance-Companies.htm. In 2009 Aetna of Connecticut and United Health Group paid their CEOs about $18,058,162 and $8,901,916, respectively.

5 Steven Reinberg, *25 Million Americans Are 'Underinsured'*, U.S.News & World Report (June 10, 2008), available at http://health.usnews.com/health-news/family-health/articles/2008/06/10/25-million-americans-are-underinsured_print.html. Nearly 42 % of adults ages 19 to 64, which is approximately 75 million Americans, were either uninsured or underinsured according to 2007 estimates.

the Patient Protection and Affordable Care Act ("PPACA"),[6] informally called the "Affordable Care Act" ("ACA"). [7]

One of the key additions to the ACA is section 2718 of the Public Health Service Act ("PHSA"),[8] which requires health insurance issuers ('issuers") offering individual or group coverage to submit annual reports to the Secretary of Health and Human Services ("Secretary") on the percentages of premiums that the issuer spends on reimbursement for clinical services and activities that improve healthcare quality ("QIA") and to provide rebates to enrollees when the issuers fail to meet the given year's minimum requirements.[9] Under the direction of section 2718, the National Association of Insurance Commissioners ("NAIC") developed uniform definitions and standardized calculating methodologies for requiring issuers to spend at least 80 to 85 percent of their premiums on actual medical care and quality," with the remaining 15 to 20 percent going towards administrative costs, marketing, and other non-healthcare related costs.[10] The NAIC defined these activities as the Medical Loss Ratio ("MLR").[11]

On December 1, 2010, the Department of Health and Human Services ("HHS") adopted and certified in full all of the recommendations of the NAIC regarding the MLRs in the interim

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[6] The Patient Protection and Affordable Care Act (hereafter, ACA), Pub.L. 111-148, Senate and House of Representatives of the United States of America in Congress, 42 USC 18001, Mar. 23, 1010, http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

[7] Michael D. Tanner, Gad Medicine, A guide to the Real Costs and Consequences of the New Health Care Law, The Cato Institute (2011), http://www.cato.org/pubs/wtpapers/BadMedicineWP.pdf.

[8] ACA), Pub.L. 111-148, Senate and House of Representatives of the United States of America in Congress, 42 USC 18001, Mar. 23, 1010, §2718, also available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. Section 2718, 42 U.S.C. 300gg-18, was added by sections 1001 and 10101 of the PPACA.

[9] Id.

[10] NAIC Adopts Final Medical Loss Ratio Regulations, National Association of Insurance Commissioners (Oct. 21, 2010), available at http://www.naic.org/Releases/2010_docs/naic_adopts_final_mlr_regs.htm,

See also, Uniform definitions and standard methodologies for medical loss ratios adopted by NAIC available at http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf

[11] Id.

final regulation implementing the MLR standards.[12] In response to consumer advocacy concerns, however, on May 16, 2012, the HHS issued an important amendment to the final rule that entered into effect on June 15, 2012, establishing a notice requirement for issuers in the group and individual markets that meet or exceed the applicable MLR standard.[13]

The HHS emphasized that the purpose of the new federal MLR standard is to help ensure that policyholders receive value for their premium dollars by requiring insurers not only to spend a defined minimum on healthcare related services, but also by requiring health insurance companies that spend less than the minimum MLR to rebate the portion of the premiums in excess of the limit starting in 2011.[14]

This paper focuses on how the HHS has interpreted the new MLR regulation particularly within the context of the MLR waivers and the MLR notice requirements. It explores the ways in which the HHS' interpretation of the rule has not met the demands of the consumer groups, while also addressing several concerns raised by the issuers. Finally the paper provides recommendations on how the HHS can provide more guidance. Mainly, the paper recommends

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12 HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, December 1, 2010, p. 74886.

The final rule was promulgated in 2011 (HHS, 45 CFR Part 158, "Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act; Final Rule," *Federal Register*, December 7, 2011).s

13 HHS, 45 CFR Part 158, "Medical Loss Ratio Rebate Requirements Under the Patient Protection and Affordable Care Act; Final Rule," *Federal Register,* May 16, 2012. Since the issuance of the final rule, the HHS issued an amendment on May 16, 2012, effective on June 15, 2012, to the regulations implementing the MLR standards, to establish a notice requirement for issuers in the group and individual markets that meet or exceed the applicable MLR standard.

14 Office of the Press Secretary, *Fact Sheet: The affordable Care Act: Secure Health Coverage for the Middle class* (June 28, 2012), available at http://www.whitehouse.gov/the-press-office/2012/06/28/fact-sheet-affordable-care-act-secure-health-coverage-middle-class. In the wake of the Supreme Court's decision, upholding the constitutionality of the "Obamacare," the office of the press secretary issued a statement stating that the main goal of ACA is to ensure that "hardworking, middle class families will get the security they deserve" and that every American is protected from the "worst insurance company abuses." The statement went on to emphasize that the ACA incorporates various provisions, such as the MLR, to "keep health care costs low, promote prevention, and hold insurance companies accountable."

that the HHS, (i) provides a clear workable definition of market destabilization, which is currently lacking, (ii) equips the Secretary with uniform principles on how to measure market destabilization when determining that the individual market is likely to destabilize due to immediate application of the federal MLR standard, (iii) requires the issuers to submit hard data, showing the likely risk of destabilization to prevent onerous and faulty waiver applications, (iv) requires timely public disclosures of MLR adjustment requests and extends the public hearing period to allow consumers ample opportunity to voice their concerns to a MLR waiver application, (v) strengthens the notice requirement by necessitating issuers to provide a frequent annual notice, (vi) removes ambiguities by requiring issuers to describe in greater detail what the MLR is, how it is calculated and what it means for the consumers, and (vii) requires issuers to disclose their current and previous year's MLRs to enable consumers to evaluate the existing issuer's performance and compare its MLRs to those of other issuers. The paper concludes with an assertion that only through the implementation of the recommended amendments will the HHS be able to guarantee that consumers' premiums are primarily spend on healthcare, rather than overhead, marketing, and extravagant executive compensation and bonuses.

II. MLR Waivers

A. HHS Requirements for MLR Adjustment in States' Individual Markets

The new federal MLR standards, established under section 2718(b)(a)(A) of the PHSA for insurance coverage provided in individual, small group and large group markets,[15] measures the percentage of the total insurance premiums that health plans use on healthcare and quality

[15] HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, December 1, 2010, p. 74886.

improvements[16] as opposed to administration, marketing and profit.[17] Accordingly, the higher a plan's MLR the higher the issuer's contribution of received premiums on health benefits rather than overhead and the higher the value to a consumer.[18] The HHS has set the MLR at a minimum of 80 percent for the individual health insurance market,[19] providing the HHS Secretary, however, with the authority to grant a waiver from the 80 percent standard under section 2718 (b)(1)(A)(ii).[20] Specifically, section 2718 (b)(1)(A)(ii) allows the HHS Secretary to adjust the 80 percent mark downwards, vis-à-vis grant a waiver, for State's individual market, "if the

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16 CSR Report for Congress (Sept. 18, 2012), p. 7-8, available at http://www.fas.org/sgp/crs/misc/R42735.pdf. The CSR Report states that "[t]o be classified as a quality initiative, spending must meet four specific criteria developed by the NAIC. An activity must: 1. Improve health outcomes by implementing activities such as quality reporting, effective case management, care coordination, chronic disease management, or medication and care compliance initiatives; 2. Implement activities to prevent hospital readmissions including a comprehensive program for hospital discharge that includes patient education and counseling, discharge planning, and post-discharge follow-up by an appropriate health care professional; 3. Implement activities to improve patient safety and reduce medical errors through the use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage; and 4. Implement wellness and health promotion activities." Additionally, HHS will consider non-claims expenses as quality improvement, but only if they meet one of the four specific criteria developed by the NAIC, mentioned above, and meet all the following requirements: 1. Designed to improve health care quality; 2. Designed to increase the likelihood of desired health outcomes in ways that can be objectively measured and that can produce verifiable results and achievements; 3. Directed toward individual enrollees or incurred for specific segments of enrollees or provide health improvements to the population beyond those enrolled in coverage, so long as no additional costs are incurred due to the non-enrollees; 4. Grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality.

17 HHS, 45 CFR Part 158, "Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act; Final Rule," *Federal Register*, Dec. 7, 2011, p. 76585.

18 CSR Report for Congress (Sept. 18, 2012), p. 1, available at http://www.fas.org/sgp/crs/misc/R42735.pdf. "The MLR is based on a health plan's overall performance, however, not on individual experience. It is an aggregate measure that in general terms compares the benefits paid to aggregate premiums."

19 HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, December 1, 2010, §158.210(a)-(c), p. 74886.

20 Id, §158.210(d), p. 74886.

Secretary determines that the application of such 80 percent may destabilize the individual market in such State." [21]

The reasoning behind the HHS's permissive regulation on waivers allowing States to apply for an adjustment to the 80 percent MLR lies in the language of section 2118(b)(A)(ii),[22] and the unique circumstances surrounding the individual market,[23] which is currently used by

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[21] Id. The waiver can be granted solely for individual health insurance market. Section 2718 does not give the Secretary the authority to grant waivers for small group or large group health insurance markets. Moreover, each of the fifty States has the power to set their own MLR rates, provided however that they meet the minimum requirements under the PHSA. Thus, when States require a higher MLR within that State, health insurance issuers are obligated to meet the higher mandate: "[F]or coverage offered in a State whose law provides that issuers in the State must meet a higher MLR than set forth in § 158.210, the State's higher percentage must be substituted for the percentage stated in § 158.210." However, in States where the MLR rates are below 80 percent, the new MLR regulation may preempt the lower MLR requirements beginning in September 23, 2010, even if the MLR rates were set prior to the PHSA (NCSL (July 2, 2012), *Medical Loss Ratios for Health Insurance*, available at http://www.ncsl.org/issues-research/health/health-insurance-medical-loss-ratios.aspx)

[22] The Patient Protection and Affordable Care Act, Pub.L. 111-148, Senate and House of Representatives of the United States of America in Congress, 42 USC 18001, Mar. 23, 2010, available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

[23] Lester Feder and Ellen-Marie Whelan, "*An Unhealthy Individual Health Insurance Market*", Center for American Progress (Dec. 23, 2008), available at http://www.americanprogress.org/issues/healthcare/news/2008/12/23/5259/an-unhealthy-individual-health-insurance-market/#1. The authors in this article emphasize the inability to pool risk as a distinctive characteristic of an individual market. In their view, risk pooling is the foundation of insurance in small and large group markets, where the premiums of all subscribers are pooled together to subsidize the cost of care of a person who gets sick. "The more people share the risk, the less each individual needs to pay into the pool." Thus, "in a pool of diverse workers, sicker and older people are balanced by healthier and younger ones." However, in the individual market, subscribers do not have anyone to share the cost with. Accordingly, "insurance companies assess how much care a subscriber is likely to require, and then limit benefits, fix deductibles, and set premiums accordingly. Not surprisingly, "premiums for individuals start at a higher rate than those for businesses, because insurers assume that those who are likely to seek out individual insurance are more likely to need care than those who do not.

Kelly Loussedes, "*NAHU Supports Legislation to Protect Consumers and Jobs*," NAHU (Feb. 3, 2012), available at http://www.nahu.org/media/releases/2012/MLR_Senate_Final.pdf. Individual market also heavily relies on agents and brokers . In particular, because individuals (and also small businesses) may be unfamiliar with different insurance coverage policies, they largely depend on "licensed agents and brokers to help them navigate the health care marketplace and find health plans that suit their needs and budgets." Many insurers argue that negotiating premiums, processing claims and enrolling employees without agents' expert advice will cause many individuals and businesses to spend more for health insurance and receive less care. Despite insurers' concerns, agents' and brokers' fees are considered an administrative cost under the current law, arguably leaving many insurers in the individual market with lower MLR ratios than they otherwise would have. As a consequence the issuers in individual markets argue that they will be unable to immediately meet the 80% MLR target and will be forced to abandon the

approximately 195.9 million Americans, or 64 percent of total population.[24] Thus, the State's insurance commissioner or other applicable State official[25] may submit an application for a temporary adjustment to the 80 percent MLR to the HHS Secretary.[26] At this point, the Secretary must review the application and determine whether the adjustment is appropriate due to the volatility of the individual market.[27] Only when the Secretary concludes that the immediate application of the 80% MLR carries the potential of destabilizing the individual market, may the

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individual market. This in turn could result in consumers struggling to find new coverage or losing their existing coverage altogether.

HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, December 1, 2010, §158.101. In light of the complicated intricacies prevalent in the individual market, section 2718(b)(A)(ii) allows the Secretary to adjust the MLR standard in the individual market if requiring compliance with the MLR may destabilize the market.

[24] Emily Smith and Caitlin Stark, *By the numbers: Health insurance*, cnn.com (June 28, 2012), available at http://www.cnn.com/2012/06/27/politics/btn-health-care/index.html. The individual market for health insurance coverage is purchased by individuals, families and sole proprietors. In comparison, group health insurance coverage is a policy that is purchased by an employer and offered to eligible employees of the company and often their family members (NAHU, *Consumer Guide To Group Health Insurance*, available at http://www.nahu.org/consumer/groupinsurance.cfm).

[25] HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, December 1, 2010, §158.310), p. 74887. Section 158.310 provides that a request for an adjustment to the MLR standard for a State be submitted by the State's insurance commissioner or other applicable State official. State insurance commissioner is of special importance for several reasons. First, State insurance commissioners have local knowledge of their State's insurance market, which makes them highly qualified and they share a responsibility to protect the general public, policy holders and enrollees within their state.

[26] See, HHS on "The 80/20 Rule: Providing Value and Rebates to Millions of Consumers" (June 21, 2012), available at http://www.healthcare.gov/law/resources/reports/mlr-rebates06212012a.html. The waiver will be granted only on a temporary annual basis. Thus, a state cannot get a permanent adjustment, but is merely given more time to comply with the 80% MLR.

[27] The Patient Protection and Affordable Care Act, Pub.L. 111-148, Senate and House of Representatives of the United States of America in Congress, 42 USC 18001, Mar. 23, 1010, http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

NCSL (July 2, 2012), *Medical Loss Ratios for Health Insurance*, available at http://www.ncsl.org/issues-research/health/health-insurance-medical-loss-ratios.aspx. As of February 2012, a total of seventeen states and Guam have requested waivers. However, only Maine, New Hampshire, Nevada, North Carolina, Iowa, Kentucky and Georgia were granted reprieves. This low number of granted waivers reflects the importance of MLR requirement that according to HHS will "provide protection and value to approximately 74.8 million insured Americans."

Secretary grant a waiver.[28] Importantly, the Secretary has a substantial discretion in deciding whether there is a possibility for market destabilization, due to the absence of uniform and clear definitions and criteria for market destabilization.[29]

B. Consumer Advocates Response to HHS' Adjustment Requirements

The consumer advocates strongly believe that the 80 percent MLR standard will effectively put more pressure on insurers to decrease premiums and become more efficient. [30] At the same time it will ensure that consumers are reimbursed for health services that they did not receive because their insurer failed to comply with the law.[31] While the consumer advocates' accept the HHS' position justifying a temporary adjustment to the MLR under special circumstances,[32] they are nevertheless concerned about the lack of a standard and effective

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[28] HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, December 1, 2010.

[29] Id.

[30] See, Letter from Consumer Groups to the NAIC (June 28, 2011) expressing their concerns about proposed methods to weaken the MLR provisions of the ACA, available at http://healthcareforamericanow.org/wp-content/uploads/2011/12/Consumer-organization-comments-on-report-to-PHIA-28June2011.pdf.

See also, e.g. Testimony of Timothy S. Jost, House Small Business Subcommittee, to the New Medical Loss Ratios, available at http://smallbusiness.house.gov/uploadedfiles/jost_testimony.pdf

[31] Id.

[32] Meg Haskell, "Feds give Maine waiver for percent insurers spend on health care," (March 9, 2011), available at http://bangordailynews.com/2011/03/08/health/maine-granted-insurance-waiver-for-medical-loss-ratio/. Main was the first state to receive a waiver to the MLR requirement. The Secretary found sufficient evidence to indicate that there is likelihood that the 80% MLR will cause insurers to exit the individual market and leave thousands of consumers without coverage. Specifically, Main has only 3 insurers that offer individual coverage. In 2010, Megalife, one of just three health insurance companies that sell individual coverage indicated that it might leave the fragile individual market in Main if the MLR were implemented. The two other companies that sell individual coverage are Anthem Blue Cross and

definition for market destabilization as well as the insufficient public hearing for adjustment requests.[33]

As of today, the final regulation, not only authorizes, but in fact requires the HHS Secretary, absent any uniform definition or test for market destabilization, to grant an adjustment to the applicable MLR whenever the Secretary finds "a reasonable likelihood that market destabilization and thus harm to consumers will occur."[34] Despite the HHS' seemingly sound justification for choosing not to bind the Secretary to any specific test,[35] the consumer advocates argue that there is a danger in the Secretary's use of different set of criteria[36] in each state that

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Blue Shield of Maine and the nonprofit Harvard Pilgrim company that administers the subsidized DirigoChoice program. Megalife's exit would have left some 14,000 Mainers looking for new, and likely more expensive, coverage. Thus, in light of these circumstances, the Secretary determined that a phase-in MLR approach is more appropriate.

[33] HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, Dec. 1, 2010, p. 74889. The HHS has not clearly defined market destabilization because it believes that it is "difficult to generalize and create a single numeric test given the different characteristics of State insurance markets, different State laws, and different types of issuers." Thus, the rule is liberally crafted to give the Secretary great discretion to decide when market destabilization is possible. The HHS provides some guidance in the 5 criteria listed under § 158.330, however, these criteria are non-binding and non-exclusive. Accordingly, the HHS has given the Secretary an excessive power to decide what criteria and what definitions to employ when making the decision. This suggests that the HHS is performing a legislative and an adjudicative function, where the Secretary acts as a fact finder.

[34] Id at 74886.

[35] Id. See fn 32. Also, the NAIC Consumer Representatives suggested in their issue resolution document that addressed market destabilization that "the Secretary consider existing State laws and historic MLRs in each State." The Secretary seeks information regarding existing State laws and issuers' MLRs in order to consider them in connection with a State's request for an adjustment of the MLR standard in the individual market.

[36] Id. §158.330. The HHS provides the Secretary with the following 5 non-binding and non-exclusive criteria: (a) The number of issuers reasonably likely to exit the State or to cease offering coverage in the State absent an adjustment to the 80 percent MLR and the resulting impact on competition in the State. In making this determination the Secretary may consider as to each issuer that is reasonably likely to exit the State: (1) Each issuer's MLR relative to an 80 percent MLR; (2) Each issuer's solvency and profitability, as measured by factors such as surplus level, risked-based capital ratio, net income, and operating or underwriting gain; (3) The requirements and limitations within the State with respect to market withdrawals; and (4) Whether each issuer covers less than 1,000 life-years in the State's individual insurance market. (b) The number of individual market enrollees covered by issuers that are reasonably likely to exit the State absent an adjustment to the 80 percent MLR. (c) Whether absent an adjustment to the 80 percent MLR standard consumers may be unable to access agents and brokers. (d) The alternate coverage options within the State available to individual market enrollees in the event an issuer exits the

submits a waiver application.[37] In particular, the use of different criteria creates different standards for market destabilization in different states.[38] Thus, the HHS' waiver policy has the advantage of providing the Secretary with sufficient flexibility to determine the unique market conditions in each applicant's individual market,[39] however, it also creates an environment of uncertainty, which might and in fact invited a number of states to almost arbitrarily apply for a waiver.[40]

One of the most prominent examples for a groundless waiver application[41] comes from the state of Florida, which drew a substantial amount of criticism[42] for its lack of substance.[43]

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market, including: (1) Any requirement that issuers who exit the State's individual market must have their block(s) of business assumed by another issuer; (2) The issuers that may remain in the State subsequent to the implementation of the 80 percent MLR, as calculated in accordance with this Part, and the nature, terms, and price of the products offered by such issuers; (3) The capacity of remaining issuers to write additional business, as measured by their risk based capital ratios; (4) The mechanisms, such as guaranteed issue products, an issuer of last resort, or a State high risk pool, available to the State to provide coverage to consumers in the event of an issuer withdrawing from the market, and the affordability of these options compared to the coverage provided by exiting or potentially exiting issuers; and (5) Any authority the State's insurance commissioner, superintendent, or comparable official may exercise with respect to stabilization of the individual insurance market. (e) The impact on premiums charged, and on benefits and cost-sharing provided, to consumers by issuers remaining in the market in the event one or more issuers were to withdraw from the market. (f) Any other relevant information submitted by the State's insurance commissioner, superintendent, or comparable official in the State's request.

[37] See fn 32 and 33

[38] Id.

[39] Id.

[40] HHS, Key Developments, "*HHS releases fact sheet regarding MLR waiver requests*," (Feb. 17, 2012), available at http://healthreformgps.org/resources/hhs-releases-fact-sheet-regarding-mlr-waiver-requests/. HHS has conducted a review of 17 states that have requested a waiver from the law's requirement that individual market health plans spend at least 80 percent of premiums on medical care or give customers rebates. In total, HHS has rejected 10 requests from North Dakota, Delaware, Texas, Kansas, Oklahoma, Florida, Indiana, Louisiana, Michigan and Wisconsin, and approved or modified applications from seven states Maine, New Hampshire, Kentucky, Nevada, Iowa, Georgia and North Carolina.

[41] Margaret Dick Tocknell, "*CMS Denies Florida's MLR Waiver Request*," HealthLeaders Media, (Dec. 16, 2011), available at http://www.healthleadersmedia.com/page-2/HEP-274382/CMS-Denies-Floridas-MLR-Waiver-Request.

[42] Carl McDonald, "Sometimes the Hardest Thing Is Knowing Which Bridge to Cross & the One to Burn - Analysis of Florida's Minimum MLR Waiver," (March 16, 2011) available at https://ir.citi.com/%2FgP0XTkW03Aafg86NrdCRpvuDF%2FoMGNXCrsxxvfE44I%3D. Citi analyst Carl MacDonald stated that "Florida's argument for significant market disruption is weak, as none of the

Organizations representing healthcare consumers and health insurance policyholders throughout the state voiced their concerns[44] in a letter to HHS Secretary, Kathleen Sebelius, about the petition submitted[45] by the Florida Office of Insurance Regulation ("OIR") seeking an outright waiver of the 80 percent MLR requirement in the Florida's individual market.[46] The HHS denied Florida's adjustment request on December 15, 2011 because it failed to provide sufficient evidence[47] that adherence to the MLR standard would result in a reasonable likelihood of market

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six largest plans in the state (which dominate the individual market, with 85% market share) will drop out of the state because of the minimum MLR requirement. Granting the waiver would also deprive consumers of an estimated $60 million in rebates based on the 2009 data."

[43] See, fn 40.

[44] Letter from Ethan Rome, HCAN executive director, to Kathleen Sebelius, HHS Secretary, (Oct 26, 2011), "*Re: Florida MLR Adjustment Application and HCAN Request for Public Hearing*" available at http://healthcareforamericanow.org/wp-content/uploads/2012/01/HCAN-public-comment-Florida.pdf. According to the Florida Office of Insurance Regulation submission, "if the adjustment is not granted, individuals and businesses in Florida will receive rebates of approximately $76 million in 2011, $51 million in 2012, and $47 million in 2013." However, "if the requested adjustments are granted, consumers will instead receive rebates of $5 million in 2011, $5 million in 2012, and $24 million in 2013." In light of this projection "the adjustment would rob Florida consumers of $140 million and give that money to insurance companies that fail to meet basic federal standards." Additionally, it "would also deprive Floridians of future savings by removing powerful incentives for insurers to lower premiums by cutting administrative expenses to achieve lower MLR thresholds."

[45] Petition of the State of Florida For an Adjustment of the MLR Provisions (March 11, 2011), available at http://cciio.cms.gov/programs/marketreforms/mlr/states/Florida/petition_mlr_03112011.pdf. Florida included several general statements that the MLR requirements will cause a reduction in the number of issuers in the individual market which will result in reduced consumer choice in that market. However, the application did not provide hard evidence of the possibility of market destabilization. However, absent a clear cut set of criteria for market destabilization, it is not surprising that the State of Florida applied for a waiver, in the hope that it might miraculously be granted.

[46] Letter from HCAN to Kathleen Sebelius, HHS Secretary, "*Re: Objections to Florida adjustment of the Medical Loss Ratio Standard in the Individual Market,*" (Oct. 27, 2011), available at http://healthcareforamericanow.org/wp-content/uploads/2012/01/Florida-Chain-and-Organize-Now-MLR-comments.pdf3_.pdf. Florida modified its application in subsequent correspondence, requesting a gradual adoption of the MLR standard: 68%, 72%, and 76% for the years 2011, 2012, and 2013, respectively.

[47] Letter from HHS to Florida's Commissioner, Kevin McCarty, "Re: State of Florida's Request for Adjustment to Medical Loss Ratio Standard" (Dec 15, 2011), available at http://cciio.cms.gov/programs/marketreforms/mlr/states/Florida/2011%201215%20FL%20MLR%20Adj%20Determination%20Letter.pdf. The HHS appears to heavily rely on the 5 criteria listed in the final regulation in its determination of whether to grant Florida's application. This, suggests that despite the broad authority given to the Secretary under the rules, the HHS still considers the five criteria to be the primary criteria in determining market destabilization. Nonetheless, the fact that these criteria are not binding gave an impression to the State of Florida that it can apply for a waiver.

destabilization and harm to consumers.[48] Steve Larsen, director of the CMS Center for Consumer Information and Insurance Oversight, noted that Florida's application received an "unprecedented level of public comment that was uniformly in opposition to the adjustment."[49]

Florida is one of 10 States that received a denial from the HHS Secretary to the request for the MLR adjustment.[50] This high rate of rejected applications[51] is promising as it reflects the importance of the MLR requirement and according to HHS will "provide protection and value to approximately 74.8 million insured Americans."[52] However, it also reflects a lack of certainty regarding when an application is warranted due to ambiguous criteria for market destabilization and thus provides incentives for States to apply for adjustments without offering hard data.[53]

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[48] Letter from Steven B. Larsen, Deputy Administrator and Director at the Center for Consumer Information and Insurance Oversight to the Honorable Kevin M. McCarty, Commissioner at the Florida Office of Insurance Regulation, "*Re: State of Florida's Request for Adjustment to Medical Loss Ratio Standard*" (Dec. 15, 2011), available at http://cciio.cms.gov/programs/marketreforms/mlr/states/Florida/2011%201215%20FL%20MLR%20Adj%20Determination%20Letter.pdf. The HHS has determined that no adjustment to the medical loss ratio standard in Florida is necessary. Florida's application provides ample evidence that the State has a competitive individual health insurance market and will allow consumers to continue to receive adequate coverage. Specifically, Florida's application shows that "most issuers in the Florida individual market either: already meet the 80 percent MLR standard, are sufficiently profitable to provide rebate payments if they fail to meet the 80 percent MLR standard, or are adapting their business models in order to provide consumers better value for their premium dollar." In light of these conclusions, the HHS does not expect "any issuers to withdraw from the Florida individual market and therefore could not conclude that it is "reasonably likely" that the market will be destabilized if the 80 percent standard is not adjusted." This determination will ensure consumers receive a better value for their premium dollar.

[49] Margaret Dick Tocknell, "*CMS Denies Florida's MLR Waiver Request*", HealthLeaders Media (Dec. 16, 2011), available at http://www.healthleadersmedia.com/print/HEP-274382/CMS-Denies-Floridas-MLR-Waiver-Request

[50] See, fn 40.

[51] Id. from the 17 states only 7 states were granted a waiver, the other 10 states were rejected.

[52] HHS Statement, "*Medical Loss Ratio: Getting Your Money's Worth on Health Insurance*," CCIIO (Dec. 2, 2011), available at http://www.ncsl.org/issues-research/health/health-insurance-medical-loss-ratios.aspx.

[53] See, Officials in 17 States Ask HHS to Phase-in MLR Requirements, http://www.healthcareexchange.com/blog/michael-gomes/officials-17-states-ask-hhs-phase-mlr-requirements (March 2, 2012, 10:58 EST).

See also, Additional Details on NAIC MLR Resolution While HHS Continues to Process State Waivers, http://www.healthcareexchange.com/blog/michael-gomes/additional-details-naic-mlr-resolution-while-hhs-continues-process-state-waivers (Nov. 29, 2011, 10:17 EST). "On the state front, many state regulators have been reluctant to back the MLR proposal out of concern for the impact the MLR would

In addition to uniform principles, the consumer advocates suggest that to prevent arbitrary waiver applications, the HHS should subject the request for adjustment to timely public disclosure[54] with an extended public hearing period[55] requiring insurers to present hard data[56] affording consumers an opportunity to actively engage in the process.[57] Ultimately, however, the waiver is only a temporary solution and the insurers would have to make necessary adjustments to conform to the new MLR requirements during the years leading up to 2014.[58]

C. Insurers Response to HHS' Adjustment Requirements

The health insurance companies that sell coverage in the individual market strongly oppose the new MLR regulation contending that it will force many insurers to abandon this

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have on their state's individual and small group health insurance markets. To help prevent major disruptions, PPACA proponents included the option for the HHS Secretary to issue temporary waivers. Many states have, or are, applying for MLR waivers in order to prevent undue disruptions in their respective insurance markets."

[54] HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, Dec. 1, 2010, p. 74886 -74888. Section 158.340 through 158.345: To ensure efficiency, the State's request for adjustment must be submitted in electronic format and will be promptly posted on the Secretary's healthcare.gov website, at which point in time the Secretary will then invite public comment and consider any comments filed by the public within 10 days of the posting. The final rule states that the State will also have an opportunity to hold a public hearing and create an evidentiary record. However, the only HHS encourages, but does not require states to hold public hearings for adjustment requests

[55] Id.

[56] See, Letter from HCAN to Kathleen Sebelius, HHS Secretary, "*OCIIO-9998-IFC*" (Jan. 31, 2011), available at http://healthcareforamericanow.org/wp-content/uploads/2011/12/HCAN-Comments-on-MLR-Rule-FINAL-31Jan11.pdf. Like the Florida example demonstrates, the request for adjustment is often missing supporting data. This is also evident from the fact that 10 out of 17 requests were in fact rejected by the HHS Secretary.

[57] Letter from HCAN to Kathleen Sebelius, HHS Secretary, "*OCIIO-9998-IFC*" (Jan. 31, 2011), supra. The Office of Consumer Information and Insurance Oversight urges the HHS in the final rule to strengthen the process as outlined in the final rule to require a public hearing for each adjustment request. "While states also are encouraged (but not required) to hold hearings regarding the such requests, experience with state-level hearings so far indicates that insurers often do not present hard data or face tough questions (Missouri) and that consumers are not invited to be full participants (Florida), depriving them of the opportunity to ask critical questions of state officials, insurance executives and producers."

[58] Testimony of Timothy S. Jost, House Small Business Subcommittee, to the New Medical Loss Ratios, available at http://smallbusiness.house.gov/uploadedfiles/jost_testimony.pdf . The fact that most insurance companies do not like the MLR requirements does not mean that they are incapable of complying with it. Neither does the fact that some insurance companies will have to accept reduced profits in order to meet the new standard.

market segment, leaving consumers either with increased premiums due to the decrease in competition for individual coverage or in the worst scenario leave them without coverage altogether. [59]

In support, the issuers advance several arguments. First, because individuals and small businesses rely heavily on insurance agents' and brokers' services to navigate through the complicate and intricate policy plans[60] the fees for such agents and brokers are part of administrative cost in the MLR calculation.[61] The issuers argue that in an effort to meet the 80 percent MLR mark, they will be forced to reduce the agents' and brokers' compensation.[62] Thus, to change the MLR formula allowing issuers to move these expenses off the books, the agents and brokers have been lobbying Congress to change the law and create a special exemption for

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[59] Kelly Loussedes, "*NAHU Supports Legislation to Protect Consumers and Jobs*," NAHU (Feb. 3, 2012), available at http://www.nahu.org/media/releases/2012/MLR_Senate_Final.pdf. Consumer choice is reduced because there will be fewer insurers in the individual market. Thus consumers will struggle to find new coverage or lose their existing coverage in the individual market.

[60] Id. Janet Trautwein, NAHU CEO, stated that "millions of individuals and small businesses depend on licensed agents and brokers to help them navigate the health care marketplace and find health plans that suit their needs and budgets, […] in fact, as the Congressional Budget Office reported, agents and brokers often serve as de facto human resources departments for many small firms -- negotiating premiums, processing claims and enrolling employees. Without agents' expert advice, many individuals and businesses will end up spending more for health insurance and receive less care."

[61] HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, Dec. 1, 2010, § 158.160(b)(2)(iv).

[62] HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, Dec. 1, 2010, p. 74877. The NAIC raised their concerns regarding the potential impact of the MLR regulation on agents' and brokers' fees and commissions. It argued that some individual market insurers in some States may be particularly reliant on producers to distribute their products. "Agents and brokers perform a range of functions on behalf of consumers and companies. In some cases, issuers may have entered into longer term compensation arrangements with agents and brokers which the MLR standard may stress. The NAIC considered, but declined to incorporate in the model regulation, special treatment for such expenses in the MLR calculations. The NAIC opted instead to establish a working group with HHS to address the impact of the ACA on agents and brokers, especially during years leading up to 2014." Accordingly, the impact of MLR standard on agents and brokers merits recognition. Thus, if the State has a valid argument that its individual market for health coverage will likely face destabilization, the HHS directs the Secretary to factor in the impact of the MLR standard on agents and brokers in the determination of whether to grant an adjustment to the MLR.

their fees.[63] However, the U.S. GAO has observed that if the bill passes, the exclusion would result in lower actual MLRs. [64] This would allow issuers to spend a lower portion of the premium dollars on healthcare and QIAs.[65]

Second, issuers contend that as insurers exit the market or change exiting policies, consumers' choice for individual insurers will greatly diminish or disappear entirely.[66]

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[63] Id. The new bill "H.R. 1206: Access to Professional Health Insurance Advisors Act of 2011" has been assigned by the committees and sent to the House or Senate as a whole for consideration on September 20, 2012. However, currently only 29% of all House bills reported favorably.

See, HCAN "Stop H.R.1206: Protect the Medical Loss Ratio" available at http://healthcareforamericanow.org/wp-content/uploads/2011/12/Oppose-HR1206-talking-points.pdf. H.R. 1206: Access to Professional Health Insurance Advisors Act of 2011 has been introduced by agents and brokers who are paid by insurance companies to sell insurance coverage to individuals, families and businesses. The fees and commissions of insurance agents and brokers are currently considered administrative expenses for the purposes of MLR. Some insurance plans have reduced such fees, citing the new MLR as the reason. In light of the fee reduction, agents and brokers have been lobbying Congress to change the law to create a special exemption for their fees. This exemption would allow insurers to continue charging as much as 30% or 40% of premiums for expenses unrelated to health care. Advocacy groups vehemently disagree with the proposal arguing that changing the treatment of agent and broker commissions would undermine the MLR formula, deny consumers rebates, and disrupt the MLR's ability to constrain premium costs. Accordingly, these changes to the MLR would ignore or purposely misclassify significant expenses.

[64] See, US Government Accountability Office Report to Congressional Requesters, "*Private Health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements*," GAO (July 2011), available at http://www.gao.gov/new.items/d11711.pdf. According to the US Government Accountability Office, almost an entire sample of seven insurers it interviewed reduced brokers' commissions and made adjustments to premiums in order to increase their MLRs as required by the PPACA.

For criticism of issuers' perspective, see also, Consumers Union Report, "Brokers Bill Could Cut Consumer Healthcare Rebates by Two-Thirds Consumers Union examines H.R. 1206 as House Committee Prepares for Markup," Consumer's Union (Sept. 19, 2012), available at http://www.consumersunion.org/pub/2012/09/018473print.html. Consumer advocates recognize that brokers have an important role in the health insurance market, however, they insist that broker's fees and commissions are inherently an administrative, not medical, cost. Brokers' commissions can absorb 10 percent or more of premiums, thus, removing them from the MLR formula would exempt a large administrative cost from the MLR calculation. The result would effectively undercut the rule's effectiveness at lowering costs and improving value for consumers. Friedholm, Director of Health Reform for Consumers Union stated: "We recognize that brokers have a role to play, particularly in the small group market, but the first concern must be the impact on consumers. And overwhelmingly, the evidence shows that MLR is working for consumers and should not be weakened by this regulation.

See also, Letter from consumer, provider and employer organizations to Congress (March 28, 2011), available at http://healthcareforamericanow.org/wp-content/uploads/2011/12/Consumer-letter-to-Hill-opposing-MLR-legislation-FINAL.pdf

[65] Id.

According to a report carried out by the NAIC Health Care Reform Actuarial Working Group and adopted by the NAIC, states with stricter MLR requirements have not observed any problems with consumer access to insurance or producers.[67] Consumers undeniably need strong market competition to keep health insurance costs down and service up,[68] however, they do not benefit from infinite health insurance choices if they provide inferior services.[69]

D. Criticism and Recommendations for HHS Waiver Policy

The main criticism of the HHS' waiver policy from the consumer advocates' side is HHS's failure to provide a clear and workable definition for what constitutes market destabilization creating an environment of uncertainty.[70] In addition the HHS failed to require

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[66] HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, Dec. 1, 2010, p. 74886.

[67] NAIC Committee Adopts MLR Report Addressing Brokers' Commissions: Study Provides Mix Findings, http://www.healthcareexchange.com/blog/michael-gomes/naic-committee-adopts-mlr-report-addressing-brokers-commissions-study-provides-mi (June 9, 2011, 13:56 EST)

[68] Email from Consumers Union to Kathleen Sebelius, HHS Secretary available at http://cciio.cms.gov/programs/marketreforms/mlr/states/Wisconsin/wi_public_comment_consumers_union.pdf.pdf

[69] Id. If some issuers exit the individual market, and thus effectively reduce consumer choice, it does not necessarily prove that consumers will be worse off. Especially, as many carriers are able to meet the new MLR standard while remain solvent and recognize profits, the HHS should allow the market to operate freely and single out inferior issuers.

[70] See, The Patient Protection and Affordable Care Act, Pub.L. 111-148, Senate and House of Representatives of the United States of America in Congress, 42 USC 18001, Mar. 23, 1010, http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. The Act merely speaks of market destabilization in the individual market, however, it does not provide any guidance as to what constitutes market destabilization. The PHSA only permits the Secretary to grant a waiver to the 80% MLR if the Secretary finds a possibility of market destabilization due to the immediate application of the 80%. However, the PHSA is silent as to any specific definition for market destabilization. It also does not afford a process or criteria under which the Secretary may make a determination regarding potential destabilization of that market. Moreover, the PHSA does not specify "the kind or amount of adjustment the Secretary may market."

See also, HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, December 1, 2010, p. 74886. The HHS could have provided a standard definition of market destabilization and give more guidance as to the criteria for determining destabilization. However, the HHS chose to remain relatively vague and ambiguous.

timely public disclosures of adjustment requests[71] with an extended public hearing period[72] requiring insurers to present hard data[73] while affording the consumers an opportunity for active participation in the process.[74] On the opposite side of the spectrum, the issuers are criticizing the HHS for imposing a crippling 80 percent MLR standard on issuers in the individual market and for computing the agents' and brokers' commission as an administrative cost in the MLR formula.[75]

Given the two extreme positions, the HHS has a difficult job trying to balance the different interests. First, to ensure that consumers receive value for their premiums and that issuers have clear guidance when they can apply for a waiver, the HHS should provide a clear, workable definition and uniform principles for how to measure destabilization in the individual market.[76] The ambiguity of the five criteria under section 158.330[77] creates a potentially

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71 HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register,* Dec. 1, 2010, p. 74886 -74888. Section 158.340 through 158.345: To insure efficiency, the State's request for adjustment must be submitted in electronic format and will be promptly posted on the Secretary's healthcare.gov website, at which point in time the Secretary will then invite public comment and consider any comments filed by the public within 10 days of the posting. The final rule states that the State will also have an opportunity to hold a public hearing and create an evidentiary record. However, the only HHS encourages, but does not require states to hold public hearings for adjustment requests

72 Id.

73 See, Letter from HCAN to Kathleen Sebelius, HHS Secretary, "*OCIIO-9998-IFC*" (Jan. 31, 2011), available at http://healthcareforamericanow.org/wp-content/uploads/2011/12/HCAN-Comments-on-MLR-Rule-FINAL-31Jan11.pdf. Like the Florida example demonstrates, the request for adjustment is often missing supporting data. This is also evident from the fact that 10 out of 17 requests were in fact rejected by the HHS Secretary.

74 Letter from HCAN to Kathleen Sebelius, HHS Secretary, "*OCIIO-9998-IFC*" (Jan. 31, 2011), supra. The Office of Consumer Information and Insurance Oversight urges the HHS in the final rule to strengthen the process as outlined in the final rule to require a public hearing for each adjustment request. "While states also are encouraged (but not required) to hold hearings regarding the such requests, experience with state-level hearings so far indicates that insurers often do not present hard data or face tough questions (Missouri) and that consumers are not invited to be full participants (Florida), depriving them of the opportunity to ask critical questions of state officials, insurance executives and producers."

75 See fn 59 and 60.

76 See fn 33.

77 See fn 36.

dangerous result[78] by effectively having different standards in determining market destabilization in different states.[79] Second, as suggested by consumer advocates, the HHS should require public disclosures of adjustment requests[80] with an extended public hearing period.[81] The extension will ensure that insurers present hard data[82] and that all interested parties, including issuers, agents and brokers, healthcare providers and consumers have an opportunity to voice their concerns regarding the MLR waiver application.[83] Third, the HHS should maintain a MLR policy of requiring agents' and brokers' fees to be calculated as an administrative cost since the impact on agents and brokers is already part of Secretary's determination within the realm of waiver

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[78] See, fn 32, 33.

See also, Letter from Ethan Rome, HCAN executive director, to Kathleen Sebelius, HHS Secretary, (Oct 26, 2011), "*Re: Florida MLR Adjustment Application and HCAN Request for Public Hearing*" available at http://healthcareforamericanow.org/wp-content/uploads/2012/01/HCAN-public-comment-Florida.pdf. As the Florida example demonstrates, waiver grant can deprive consumers of $140 million. This example demonstrates, how important it is to be able to anticipate when a State can receive a waiver so that the consumers can expect to get rebates.

[79] See fn 37. The clear criteria will create more certainty forcing insurers to submit hard data.

[80] HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, Dec. 1, 2010, p. 74886 -74888. Section 158.340 through 158.345: To insure efficiency, the State's request for adjustment must be submitted in electronic format and will be promptly posted on the Secretary's healthcare.gov website, at which point in time the Secretary will then invite public comment and consider any comments filed by the public within 10 days of the posting. Once the Secretary concludes that the State's request for an adjustment to the MLR standard is sufficient under section 158.330 and the public comment period has expired, the Secretary will make a resolution generally within 30 days, but not more than 60 days, to either grant or deny the State's request. The final rule states that the State will also have an opportunity to hold a public hearing and create an evidentiary record. However, the only HHS encourages, but does not require states to hold public hearings for adjustment requests

[81] Id.

[82] See, Letter from HCAN to Kathleen Sebelius, HHS Secretary, "*OCIIO-9998-IFC*" (Jan. 31, 2011), available at http://healthcareforamericanow.org/wp-content/uploads/2011/12/HCAN-Comments-on-MLR-Rule-FINAL-31Jan11.pdf. Like the Florida example demonstrates, the request for adjustment is often missing supporting data. This is also evident from the fact that 10 out of 17 requests were in fact rejected by the HHS Secretary.

[83] Id. The Office of Consumer Information and Insurance Oversight urges the HHS in the final rule to strengthen the process as outlined in the final rule to require a public hearing for each adjustment request. "While states also are encouraged (but not required) to hold hearings regarding the such requests, experience with state-level hearings so far indicates that insurers often do not present hard data or face tough questions (Missouri) and that consumers are not invited to be full participants (Florida), depriving them of the opportunity to ask critical questions of state officials, insurance executives and producers."

applications.[84] Moreover, as the Director of Health Reform for Consumers Union, DeAnn Friedholm, pointed out that there is overwhelming evidence showing that the MLR is working for consumers and therefore should not be weakened by this regulation.[85] In the end, consumers do not benefit from infinite health insurance choices if they provide inferior services.[86]

III. Notice Requirements

A. HHS' Interpretation of Notice Requirement

In response to public comments, the HHS issued an amendment to the final regulation on May 16, 2012, effective on June 15, 2012, establishing a onetime simple notice requirement for all issuers in the group and individual markets that meet or exceed the applicable MLR standard in the 2011 MLR reporting year.[87]

The amendment introduced new notice requirements to ensure that all consumers, regardless of whether they are owed a rebate, receive an informational notice informing them

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[84] See fn. 64.

[85] Id.

[86] Email from Consumers Union to Kathleen Sebelius, HHS Secretary available at http://cciio.cms.gov/programs/marketreforms/mlr/states/Wisconsin/wi_public_comment_consumers_union.pdf.pdf Consumers undeniably need strong market competition to keep health insurance costs down and service up. However, if some issuers exit the individual market, and thus effectively reduce consumer choice, it does not necessarily prove that consumers will be worse off. Especially, as many carriers are able to meet the new MLR standard while remain solvent and recognize profits, the HHS should allow the market to operate freely and single out inferior issuers.

See also, Peter Harbage, "*The Inefficient Individual Health Insurance Market*," Center for American Progress Action Fund (March 23, 2009), available at http://www.americanprogressaction.org/issues/healthcare/report/2009/03/23/5802/the-inefficient-individual-health-insurance-market/ "The Congressional Budget Office estimates that 29 percent of premium dollars in the individual insurance market go toward administrative costs on average. This is more than double the average rate in the group market, where roughly 12 percent of employer-sponsored insurance premium dollars are spent on administrative costs."

[87] HHS, 45 CFR Part 158, "Medical Loss Ratio Rebate Requirements Under the Patient Protection and Affordable Care Act; Final Rule," *Federal Register*, May 16, 2012, §158.251(a)(1), p. 28797. Thus, even for issuers that meet or exceed the MLR target, the HHS requires to provide a simple notice of the MLR information to policyholders on or after July 1, 2012 with the first plan document. Accordingly, this notice requirement applies only for the 2011 reporting year.

whether the issuer has met or exceeded the minimum MLR requirement for current year.[88] The notice must also provide consumers with educational information regarding the MLR rule,[89] but only in the first year when MLR is applied to increase consumers' understanding of the significance and implications of the MLR.[90] The amendment does not require issuers to include the issuer's current or previous year's MLR if the issuer has met or exceeded the standard, rather the notice must merely direct the subscribers to the HHS website, HealthCare.gov., where they can find issuers' actual MLRs and compare MLR information across issuers and years.[91]

In addition to the standard language requirements, the HHS prescribes that the notice be prominently and clearly displayed on the front of the plan document, insurance policy or certificate.[92] Alternatively, it can also be written separately and may be included in the same mailing as other mailed notices[93] or it can be send electronically consistent with the

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[88] Id. See, §158.251(a)(2) for issuers that meet or exceed the MLR target.
See also, HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, Dec. 1, 2010, §158.250, p. 74885. Section 158.250 requires issuers that did not meet the MLR target to provide enrollees with a rebate notification along with any rebate check or premium credit. "The rebate notification must include a brief explanation of what an MLR is, why the ACA created the policy (for example, increased transparency, incentive to lower premiums), and why the enrollee is receiving a rebate. It must also include the aggregate amount of premium revenue reported by the issuer during the MLR reporting year, the issuer MLR [], the required MLR threshold, [etc.]" HHS includes three reasons for this requirement. First, "[e]nrollees may not understand why they are receiving a rebate and may not be familiar with the significance of the MLR and the rebate requirement in the Affordable Care Act." Second, "enrollees have no explanation as to how rebates are calculated." Third, MLR transparency is a way to educate consumers and promote informed decision-making in the purchasing of health insurance."

[89] See, example of MLR notice with rebate from Florida UnitedHealthcare, available at http://broker.uhc.com/assets/reform-MLR-external-letter-explanation-of-payment-sample.pdf
See also, example of MLR notice from Horizon BCBS of NJ that met or exceeded the MLR, available at http://www.horizonblue.com/sites/default/files/pdf/871%20-%20BB%202012%20MLR%20Notice%204%20FINAL.pdf

[90] See fn 86.

[91] Id, see also fn 87.

[92] HHS, 45 CFR Part 158, "Medical Loss Ratio Rebate Requirements Under the Patient Protection and Affordable Care Act; Final Rule," *Federal Register*, May 16, 2012. §158.251(a)(3).

[93] Id.

requirements for electronic disclosure under section 2715 of the PHSA.[94] With the standard language requirements and expansive mailing options, the HHS attempted to minimize the burden on the issuers[95] while attempting to educate consumers about the new law.[96]

B. Consumers Position on HHS' Notice Requirement

Consumer advocates are generally satisfied with the amendments to the final rule.[97] However, they recommend strengthening the rule[98] and remove ambiguities in several areas,[99] as well as, to require issuers to disclose their current and previous year's MLRs.[100] These measures will increase health plan transparency,[101] reduce consumer confusion[102] and insure that all

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94 Id.

95 Id. According to the HHS estimates, approximately 278 to 337 issuers that provide services to 65.8 million to 72.2 million subscribers will meet or exceed the minimum MLR standard and hence be subject to the new notice requirement. Thus, to minimize the burden on the issuers, the HHS requires issuers to use standard language for notices and gives issuers' an option of providing the notices with other plan documents or submitting them electronically in compliance with section 2715 of the PHSA. These cost saving measures would keep administrative cost of preparing and mailing the MLR notices only at about 3 million in 2012 for the 2011 reporting year, which is about $0.16 per notice, including labor and supply costs.

96 See, fn. 86.

97 HHS, 45 CFR Part 158, "Medical Loss Ratio Rebate Requirements Under the Patient Protection and Affordable Care Act; Final Rule," *Federal Register*, May 16, 2012, p. 28791.

See also, Letter from Consumer Groups to the HHS, "RE: File Code CMS-9998-FC (Medical Loss Ratio Requirements)" (Jan. 6, 2012), available at http://healthcareforamericanow.org/wp-content/uploads/2012/01/mlr-final-rule-consumer-comments-Final.pdf.

98 Id . Consumer advocacy groups believe that every subscriber of a fully insured product, not just the ones that are owed a rebate, should receive an annual, rather than a onetime notice. A onetime notice is better than no notice, however, there is a danger that the subscriber either does not receive the notice or simply does not pay attention to its significance. A yearly notice increases the chances that the subscribers will read about the MLR rule and its implications.

99 Id. Currently, the HHS requires a general, standard language to inform consumers of MLR. However, the final rule does not demand any detailed account of why the issuer did not meet the MLR and how exactly MLR is calculated. By requiring issuers to describe in greater detail what MLR is, how it is calculated and what it means for the consumers, consumers will be able to better informed about the benefits of MLR, which would further the purpose of the ACA.

100 See, Letter from Consumer Groups to the HHS, "RE: File Code CMS-9998-FC (Medical Loss Ratio Requirements)" (Jan. 6, 2012), available at http://healthcareforamericanow.org/wp-content/uploads/2012/01/mlr-final-rule-consumer-comments-Final.pdf

101 Id.

102 Id.

subscribers, not just the ones that are owed a rebate, receive information about the nature and purpose of the MLR, and are able to evaluate the existing issuer's performance.[103]

First, the consumer advocacy groups believe that every subscriber of a fully insured product, not just the ones that are owed a rebate, should receive a notice that is sent out annually rather than once.[104] The concern is that if the communications about the purpose of the MLR are infrequent or made only to a selected group of enrollees, there is a risk that not all consumers will in fact be educated about the new law and thus lose the benefits associated with MLR.[105] In addition, even assuming that every subscriber receives the notice and understands the implications of the MLR regulation, future subscribers will not have the same opportunity.[106]

Second, due to the enormous intricacies of the healthcare reform,[107] consumer advocacy groups demand a higher level of detail from the issuers regarding the new MLR notice requirements.[108] The burden of providing detailed information about the MLR should rest with

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[103] See, fn 97.

[104] Id. Enrollees who are entitled to rebates would receive a more detailed notice explaining the rebate.

[105] Id. "A regular, annual communication would accomplish several things. (1) Consumers can begin to learn about this dimension of their health plan via a well-crafted notice. If these communications are made infrequently to only a handful of consumers, the goal of increased transparency will not be accomplished. (2) If the goal of informed decision making is to be realized, consumers must be able to connect strong MLRs with the correct health plans. Clear notices, in conjunction with the posting of plan MLR data on the HHS website (as required by Section 2718(a) of the ACA), are essential to achieving that end."

[106] Id. Because the HHS only requires a onetime notice, all future subscribers will not have the same opportunity to learn about the MLR regulation.

[107] Mark Blumenthal, "Obamacare Ruling: Polls Point To Confusion, Unhappiness No Matter What," huffingtonpost.com (June, 26, 2012), available at http://www.huffingtonpost.com/2012/06/26/polls-obamacare-supreme-court-ruling_n_1628561.html "The Kaiser Family Foundation has found just less than half of Americans -- ranging between 42 and 55 percent, with no apparent trend -- say that the word "confused" describes their feelings about the health care law."

[108] See, Letter from Consumer Groups to the HHS, "RE: File Code CMS-9998-FC (Medical Loss Ratio Requirements)" (Jan. 6, 2012), available at http://healthcareforamericanow.org/wp-content/uploads/2012/01/mlr-final-rule-consumer-comments-Final.pdf

the issuers, who have more resources[109] and greater expertise to sift through the complicated language of the MLR regulation and thus are in a better position to educate consumers about the new rule. [110] Consumer advocates are especially concerned about possibility of issuers taking advantage of consumers' lack of understanding of the MLR and its calculation in an attempt to avoid spending the required 80 percent on healthcare or activities that improve its quality.[111] Accordingly, the perception is that if consumers receive more information about the MLR, there is a higher chance that they will know how much of their premium dollars their current issuer spends on healthcare and QIAs.[112]

Third, consumer advocacy groups recommend that the frequent notices include in conjunction with an MLR description, the subscribers plans' current and previous year's MLRs,

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[109] HHS, 45 CFR Part 158, "Medical Loss Ratio Rebate Requirements Under the Patient Protection and Affordable Care Act; Final Rule," *Federal Register*, May 16, 2012, p. 28795. Issuers are in a better position than average subscribers to provide information about MLR at a minimal cost of $0.16 per notice.

[110] See, HHS, "CMS releases final rule on MLR requirements" (May 12, 2012) available at http://www.healthreformgps.org/resources/cms-releases-final-rule-on-mlr-requirements/ "The goal of the notice is to educate consumers regarding the MLR measures and to help consumers know that the majority of premium payments go towards health care, as opposed to advertising, executive bonuses, or administrative overhead costs." Accordingly, it is only sensible that HHS would require issuers to alert policyholders and subscribers about the MLR existence.

[111] See fn 63.

See also, H.R. 1206: Access to Professional Health Insurance Advisors Act of 2011, available at http://www.gpo.gov/fdsys/pkg/BILLS-112hr1206ih/pdf/BILLS-112hr1206ih.pdf. This new bill is the most controversial example of a situation where issuers can take advantage of consumer's ignorance about the MLR formula. This new bill creates an exemption for agents and brokers by excluding their fees from the MLR formula allowing issuers to move these expenses off the books. This exclusion would result in lower actual MLRs allowing issuers to spend a lower portion of the premium dollars on health care and quality improvement. Thus, the MLR will no longer be a useful indicator of how much issuers actually spend on health care and overhead. This example perfectly illustrates the need for educating consumers about the MLR rule and the need for more transparency.

[112] HHS, 45 CFR Part 158, "Medical Loss Ratio Rebate Requirements Under the Patient Protection and Affordable Care Act; Final Rule," *Federal Register*, May 16, 2012, p. 28793.

See also, Peter Harbage, "*The Inefficient Individual Health Insurance Market*," Center for American Progress Action Fund (March 23, 2009), available at http://www.americanprogressaction.org/issues/healthcare/report/2009/03/23/5802/the-inefficient-individual-health-insurance-market/ "The Congressional Budget Office estimates that 29 percent of premium dollars in the individual insurance market go toward administrative costs on average. This is more than double the average rate in the group market, where roughly 12 percent of employer-sponsored insurance premium dollars are spent on administrative costs."

which will reduce confusion as to whether the policyholder is entitled to a rebate or not[113] and allow consumers to evaluate and compare the issuer's two year performance with other issuers.[114] This ability would allow consumers not only to understand the issuers' efficient use of the premium revenue, but ultimately help consumers to better utilize the MLR information when making plan choices.[115] Currently, the final regulation relies on the issuers' voluntariness in providing a notification about the MLR and the fact that no rebate is owed.[116] However, consumer advocates argue that such reliance is impractical, rather unrealistic,[117] and will result in random notifications.[118] This in fact can lead to counterproductive outcomes because random notices will not only spread more confusion and irritation among the consumers, if the issuers spontaneously decide to start sending out random notices, [119] but will also fail to establish a ubiquitous presence vital in creation of new expectations among consumers.[120]

C. Insurers' Position on HHS' Notice Requirement

Health insurance issuers strongly oppose the updated notice requirement in the final regulation,[121] because it not only unnecessarily increases administrative costs for issuers that

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113 HHS, 45 CFR Part 158, "Medical Loss Ratio Rebate Requirements Under the Patient Protection and Affordable Care Act; Final Rule," *Federal Register*, May 16, 2012, p. 28794.

114 Letter from consumer, patients and employees to the HHS, "*Re: File Code CMS-9998-FC (Medical Loss Ratio Requirements,*" (Jan. 6, 2012), available at http://healthcareforamericanow.org/wp-content/uploads/2012/01/mlr-final-rule-consumer-comments-Final.pdf

115 Id.

116 HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, Dec. 1, 2010, §158.250, p. 74885. The "HHS is not requiring issuers who do not have to provide a rebate to provide notification to enrollees about the MLR and the fact that no rebate is owed. However, issuers who do meet the MLR standard may choose to provide such notice to their enrollees."

117 Id.

118 See fn 104.

119 Id.

120 See, fn 112.

121 HHS, 45 CFR Part 158, "Medical Loss Ratio Rebate Requirements Under the Patient Protection and Affordable Care Act; Final Rule," *Federal Register*, May 16, 2012, p. 28791.

meet or exceed the MLR target, but also confuses consumers and provides them with little value.[122]

First, the issuers argue that the additional notification requirements would affect a large number of issuers[123] in the individual and group markets that meet or exceed the applicable MLR requirement imposing an unnecessary burden on such issuers.[124] However, according to the HHS estimates, the total administrative cost for preparing and mailing notices to issuers that meet or exceed the MLR target would amount to approximately three million dollars, an average cost of merely $9,000 to 10,000 per issuer for the 2011 reporting year.[125] This amount translates to an average added cost of $0.16 per enrollee for preparing and sending a notice by mail, including labor and supply costs.[126] Thus, the issuers concerns seem unjustified since the incurred expenses are rather minimal, and under the current regulation, are a one-time cost.[127]

Second, the issuers argue that the amended notice rule will spread confusion among consumers and therefore provide very little value.[128] Thus, consumers could either misinterpret the MLR information provided in the notices, or may mistakenly believe that they are owed a rebate.[129] This concern appears reasonable; however, not because consumers will receive the

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122 Id.

123 HHS, 45 CFR Part 158, "Medical Loss Ratio Rebate Requirements Under the Patient Protection and Affordable Care Act; Final Rule," *Federal Register*, May 16, 2012, p. 28795. The HHS estimated that that in 2012, between 278 and 337 issuers will send MLR notices for the 2011 MLR reporting year to 29.9 million to 32.7 million individual market and group market subscribers.

124 Id.

125 Id.

126 Id.

127 Id. The HHS took the issuers' administrative burden into account in the amended final regulation and requires merely a one-time notice from issuers in individual and group markets that meet or exceed the applicable MLR standard.

128 Id at 28791.

129 Id.

MLR notice, but rather because consumers will receive this notice only once instead of annually, creating more uncertainty and less transparency.[130]

Finally, the issuers fear that the updated mandatory notice requirement will not only confuse, but likely mislead consumers leading to dangerously mistaken inferences regarding issuers' performance.[131] Essentially, the issuers argue that an issuer's MLR from the current and prior reporting year is not necessarily a reliable indicator of health plan performance,[132] because it ignores the real catalyst of rising premiums[133] and fails to take into consideration, value

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[130] Id. See also, Letter from Consumer Groups to the HHS, "RE: File Code CMS-9998-FC (Medical Loss Ratio Requirements)" (Jan. 6, 2012), available at http://healthcareforamericanow.org/wp-content/uploads/2012/01/mlr-final-rule-consumer-comments-Final.pdf. The HHS Secretary Kathleen Sebelius said in a blog to consumers that "If your insurance company is providing fair value for your premium dollars, you should know that."[130] However, in order for the Secretary's statement to have teeth, the notice should be expanded as proposed by the consumer advocacy groups.

[131] J C Robinson, "*Use and abuse of the medical loss ratio to measure health plan performance*," Health Affairs, 16, no.4 (1997):176-187, http://content.healthaffairs.org/content/16/4/176.full.pdf.

[132] Id. "The medical loss ratio is a ratio of medical expenditures to insurance premiums. High ratios can be achieved either through a large numerator (high medical expenditures) or through a small denominator (low insurance premiums). The medical loss ratio, as a ratio of the two, can be measuring the impact of medical market competition on expenditures or of insurance market competition on premiums. For example, a statistical analysis of medical loss ratios in three states found that administrative loss ratios were higher (and medical loss ratios were lower) in plans that relied extensively on capitation rather than on fee-for-service; this difference was attributable solely to the lower total premiums charged by the capitation-oriented plans (the denominator of the medical loss ratio) rather than to differences in administrative expenses per enrollee. Moreover, neither premiums nor expenditures by themselves indicate quality of care. More direct measures of quality are available, including patient satisfaction surveys, preventive services use, and severity-adjusted clinical outcomes. Although each of these is limited in scope, they at least shed light on quality of care. The medical loss ratio does not." In addition the article emphasizes that "health insurers, interpret the variation in rates of medical and surgical procedures across U.S. geographic areas as indicators of inefficiency within the medical care delivery system." In fact they "interpret high medical loss ratios as proof of medical waste." Accordingly, "the medical loss ratio sheds no clear light on medical or administrative expenditures and so cannot illuminate the much murkier issue of medical or administrative waste."

[133] See, AHIP Statement on the Medical Loss Ratio Requirement (April 26, 2012) available at http://www.ahip.org/News/Press-Room/2012/AHIP-Statement-on-the-Medical-Loss-Ratio-Requirement.aspx.

See also, Annemarie Bridy, "Secret Prices & High-Tech Devices: How Medical Device Manufacturers are Seeking to Sustain Profits by Propertizing Prices," Texas Intellectual Property Law Journal (Feb. 9, 2009), available at http://ssrn.com/abstract=1242462. "One study conducted in 2002 found drugs and medical devices together accounted for 22% of healthcare insurance premium increases in the U.S. from 2001 to 2002."

depreciating,[134] and what the issuers claim, value enhancing services,[135] that are not captured in the MLR formula, but that can either positively or negatively affect the issuers' year-to-year MLRs.[136] Accordingly, issuers can enlarge their MLRs if they, for instance, reduce agents' and brokers' commissions, reduce the number or in-network physicians or decrease other expenses on services that do not constitute QIA under the current MLR regulation.[137] On the other hand, the new regulation reduces issuers MLRs because the HHS does not consider many of the services provided by issuers to their subscribers as quality improvement activity.[138] One such example is the fraud prevention activity, which is considered an administrative expense.[139]

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[134] US Government Accountability Office Report to Congressional Requesters, "*Private Health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements*," GAO (July 2011), available at http://www.gao.gov/new.items/d11711.pdf.

[135] HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, December 1, 2010, §158.150(c), p. 74924. §158.150(c) lists various exclusions from the list of permissible quality health care improvement activities.

[136] Id. "The medical loss ratio is an accounting monstrosity, a convolution of data from myriad products, distribution channels, and geographic regions that enthralls the unsophisticated observer and distorts the policy discourse." MLR can be affected by variation in incurred claims, premium revenue, or adjustments.

[137] US Government Accountability Office Report to Congressional Requesters, "*Private Health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements*," GAO (July 2011), available at http://www.gao.gov/new.items/d11711.pdf. HHS does not consider reduction in agents' and brokers' commission, or the number of in-network physicians quality improvement activities. Thus, the issuers argue that all of these activities effectively enlarge the MLR ratio without actually providing any additional services to the consumers.

[138] Sara Hansard, HHS Finalizes Requirement to Notify Consumers When MLR Spending Targets Met," Bloomberg BNA (May 16, 2012), available at http://www.bna.com/hhs-finalizes-requirement-n12884909399/.

[139] HHS, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, December 1, 2010, §158.150(b), p. 74924. Under section 158.150(c)(8), fraud prevention activities, other than fraud detection and recovery expenses up to the amount recovered that reduces incurred claims are excluded from the list of permissible quality improvement activities.

See also, Sara Hansard, HHS Finalizes Requirement to Notify Consumers When MLR Spending Targets Met," Bloomberg BNA (May 16, 2012), available at http://www.bna.com/hhs-finalizes-requirement-n12884909399/.

See also, America's Health Insurance Plans, "Interim Final Rule – Medical Loss Ratio Requirements," January 31, 2011, http://www.ahip.org/Issues/Medical-Loss-Ratio.aspx. One issue that has been raised in the definition of quality improvement activities ("QIA") is whether fraud reduction and prevention activities can be included within the list of permissible quality improvement expenses.

However, issuers have argued that fraud prevention activities "improve patient safety and deter the use of medically unnecessary services, thus providing a higher level of healthcare quality."[140] The HHS rejected issuers' argument stating that it will continue to exclude fraud prevention activities from QIA[141] and allow inclusion only of payments recovered through fraud reduction efforts as adjustments to incurred claims, which in turn has the potential of increasing issuers MLRs.[142] The debate over QIA exemplifies the complexity of what exactly is included in the MLR and accordingly supports issuers' argument that providing consumers with MLRs would only create confusion and lead to mistaken inferences.[143] For that reason, issuers believe that comparing the year-to-year MLRs could mislead consumers.[144]

D. Criticism and Recommendations for HHS Notice Requirement Policy

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[140] HHS, 45 CFR Part 158, "Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act; Final Rule," *Federal Register*, December 7, 2011, p. 76577. However, some provider associations expressed their concerns about characterizing fraud prevention activities as QIA stating that the lack of clear definition for fraud detection and recovery may lead to improper characterization of certain activities as fraud detection. In particular, failure to include all fraud reduction efforts under QIA would cause issuers to reduce their fraud detection efforts, decrease patient safety and quality of care and thus undercut the federal government's efforts in preventing and prosecuting fraud.

[141] HHS, 45 CFR Part 158, "Medical Loss Ratio Rebate Requirements Under the Patient Protection and Affordable Care Act; Final Rule," Federal Register, May 16, 2012, p. 28791. HHS looks at these concerns as unpersuasive since issuers will most likely continue to invest in fraud reduction and prevention, regardless of MLR treatment in light of the enormous net savings from anti-fraud operations. In 2008 the net savings from anti-fraud operations were more than $3 per enrollee among large issuers, $1 per enrollee among medium sized issuers and $2.7 per enrollee among small issuers.

[142] Id. This compromise, according to HHS, will give issuers an opportunity to recover monies invested to deter fraud, and thus mitigate any disincentives issuers may have to invest in these activities,[142] while at the same time preserving the purpose of requiring issuers to comply with the applicable MLR standard in the ACA.

[143] See also, US Government Accountability Office Report to Congressional Requesters, "*Private Health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements*," GAO (July 2011), available at http://www.gao.gov/new.items/d11711.pdf. Essentially, the issuers argue that by reducing other services that they consider either health care or quality improving activity expenses, they can manipulate the MLRs without actually increasing their spending on actual health and quality improvement services. However, the HHS has already determined what constitutes QIAs, thus it may actually benefit the consumers if the administrative costs, such as agents' and brokers' fees, are in fact reduced, which will in turn reduce the cost of health care.

[144] Id.

Consumer advocates key demand is that the HHS should strengthen and remove ambiguities from the mandatory MLR notice requirements and require the issuers to disclose their current and previous year's MLRs.[145] On the other hand, issuers believe that the current notice requirements already impose an unnecessary burden on the issuers that meet or exceed the applicable standard and are likely to spread confusion and lead to misinterpretation of the issuers' MLRs.[146]

In an attempt to find the right course of action and meet the demands of the opposing interest groups, the HHS adopted a balanced approach seeking to minimize the cost of additional notice requirement to the issuers while protecting the interests of consumers.[147] Essentially, the HHS determined that on one hand, failing to require MLR information notices from issuers that meet or exceed the applicable MLR standard would result in reduced transparency regarding how the issuers spend their premium dollars,[148] whereas on the other hand, any greater notice requirements, like those demanded by the consumer advocates, would impose a greater burden on the issuers than is necessary.[149] However, the HHS misses the mark by requiring merely a simple onetime notice, rather than an ongoing annual MLR notice that includes general information as well as issuer's current and previous year's MLR since such additional requirements create important benefits for both issuers and consumers.[150]

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145 See, Letter from Consumer Groups to the HHS, "RE: File Code CMS-9998-FC (Medical Loss Ratio Requirements)" (Jan. 6, 2012), available at http://healthcareforamericanow.org/wp-content/uploads/2012/01/mlr-final-rule-consumer-comments-Final.pdf

146 HHS, 45 CFR Part 158, "Medical Loss Ratio Rebate Requirements Under the Patient Protection and Affordable Care Act; Final Rule," Federal Register, May 16, 2012, p. 28791.

147 Id at 28792.

148 Id. at 28796.

149 Id.

150 See all fn below.

Frist, random notices will only increase confusion and irritation among the consumers.[151] The ongoing annual MLR notices, on the other hand, will establish a ubiquitous presence, which is essential in creation of new expectations among consumers.[152] Knowing where and how the premiums are spend, will likely reduce consumers' resentment and disappointment with the relentless annual health insurance cost increases.[153] Moreover, the HHS itself predicts that, through the notice requirement, the insurers will have an incentive to "maximize the percentage of premium dollars they spend on healthcare and activities that improve healthcare quality" rather than spend the absolute minimum in order to avoid paying out rebates. [154] Thus, the HHS should follow its own prediction and establish an annual MLR notice requirement, which is essential in overcoming uncertainty and increasing consumer understanding of how their dollars are spend.[155]

Second, the issuers unfortunately believe that providing consumers with more information in the notice will be too burdensome and counterproductive.[156] However, the general information about the MLR and the actual MLR numbers will be available on the HHS website anyway, which must be referenced in the notices.[157] Thus, by requiring the issuers to provide more information in the actual MLR notices, the HHS would only ease consumers' access to

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151 Letter from consumer, patients and employees to the HHS, "*Re: File Code CMS-9998-FC (Medical Loss Ratio Requirements*," (Jan. 6, 2012), available at http://healthcareforamericanow.org/wp-content/uploads/2012/01/mlr-final-rule-consumer-comments-Final.pdf

152 See, fn 112.

153 See Reed Abelson, "Health Insurance Costs Rising Sharply This Year, Study Shows," (Sept. 27, 2011), available at http://www.nytimes.com/2011/09/28/business/health-insurance-costs-rise-sharply-this-year-study-shows.html?pagewanted=all. "The steep increase in rates is particularly unwelcome at a time when the economy is still sputtering and unemployment continues to hover at about 9 percent. Many businesses cite the high cost of coverage as a factor in their decision not to hire, and health insurance has become increasingly unaffordable for more Americans. Over all, the cost of family coverage has about doubled since 2001, when premiums averaged $7,061, compared with a 34 percent gain in wages over the same period."

154 HHS, 45 CFR Part 158, "Medical Loss Ratio Rebate Requirements Under the Patient Protection and Affordable Care Act; Final Rule," Federal Register, May 16, 2012, p. 28793.

155 Id.

156 Id at 28793.

157 Id. at 28791.

such information and enable consumers to evaluate their issuer's performance on the spot, rather than open entirely new doors to such data. Also, issuers argument that the consumers might misinterpret the MLR information because the MLR formula is complex and contains disputed activities,[158] is unpersuasive. [159] The NAIC and the HHS have already determined that MLR is a reliable measure of issuers' performance in terms of their spending on healthcare and QIA versus administrative costs.[160] Accordingly, the HHS should require issuers to include more information about the MLR in general, and demand that issuers' provide their current and past year's MLRs.

Third, issuers argue vehemently that the mandatory notice requirement is too costly.[161] However, the HHS has already determined that the benefits to consumers will outweigh the administrative costs incurred by insurers through the issuance of notices to the policyholders.[162] In particular, according to the HHS estimates, the total administrative cost for preparing and mailing notices to issuers that meet or exceed the MLR target would merely amount to approximately three million dollars, an average cost of $9,000 to 10,000 per issuer for the 2011 reporting year,[163] translating to an average added cost of $0.16 per enrollee for preparing and sending a notice by mail, including labor and supply costs.[164] Importantly, the estimates are for the first time notices only.[165] Thus, it is reasonable to assume that by requiring frequent annual notices, the cost of such notices can be reduced even further over time as the notices become

158 See fn 132. Issuers refer to fraud prevention activity, or agents' and brokers' commission.
159 See fn 137.
160 Id.
161 See fn 123-126.
162 Id., See also HHS, 45 CFR Part 158, "Medical Loss Ratio Rebate Requirements Under the Patient Protection and Affordable Care Act; Final Rule," Federal Register, May 16, 2012, p 28793-28794.
163 Id.
164 Id.
165 Id.

more automated.[166] This only supports the recommendation that the HHS should require annual notices.

Thus, with these important amendments to the final rule the HHS can expect to achieve greater transparency and more accountability regarding how the issuers use their premium revenue, which is the main purpose of the ACA.[167]

I. Conclusion

The American healthcare system is in a desperate need for significant reforms since it is riddled with inefficiencies and excessive administrative costs. With the passage of the new MLR regulation, embedded in the ACA, the Obama administration attempts to restore confidence into the healthcare system by holding health insurance issuers accountable for their expenses and ensure that the American people receive value for their premium dollars.

The new rule requires issuers in small group and individual health insurance markets to spend at least 80 percent and issuers in large group market to spend at least 85 percent of the premiums on healthcare and quality improvement activities. However, as this paper argues, the HHS's interpretation of the MLR requirement has failed to adequately address many consumer concerns as they relate to the MLR waiver policy in the individual market and the MLR notice requirements for issuers in group and individual markets that meet or exceed the applicable MLR requirement.

This paper has examined two competing positions on waivers and the notice requirements proposed by the consumer advocates and the issuers, and investigated the HHS' success in attempting to balance these different interests. Having identified several troubling parts, the paper offers important recommendations for the HHS to provide more guidance and improve the

166 Id.

167 See fn 14.

current regulation. Several important recommendations advise the HHS to provide a clear workable definition for market destabilization, and to demand timely public disclosure of the MLR waiver request in conjunction with hard data and extension of the public hearing period to permit all interested parties to participate in the waiver process. In addition, the HHS is advised to require an annual mandatory MLR notice from all issuers that describes in greater detail what the MLR is and discloses the issuers current and previous year's MLRs.

In summary, the HHS has promulgated an important consumer empowering regulation, but there is still a lot of work to be done. After many years of being held in the dark about healthcare spending, consumers deserve to know how their premium dollars are spend and demand that the bulk of their premium dollars is primarily spend on healthcare and QIA, instead of overhead, marketing, advertising and extravagant CEO bonuses.