



United States Government Accountability Office
Washington, DC 20548

October 31, 2011

The Honorable Robert E. Andrews
Ranking Member
Subcommittee on Health, Employment, Labor, and Pensions
Committee on Education and the Workforce
House of Representatives

The Honorable John F. Tierney
House of Representatives

Subject: *Private Health Insurance: Early Indicators Show That Most Insurers Would Have Met or Exceeded New Medical Loss Ratio Standards*

To help ensure that millions of Americans who rely on private insurance for health care coverage receive value for their premium dollars, the Patient Protection and Affordable Care Act (PPACA) established minimum “medical loss ratio” (MLR) standards for insurers.¹ The MLR is a basic financial indicator, traditionally referring to the percentage of insurance premium revenues health insurers spent on their enrollees’ medical claims. The MLR definition specified in the PPACA provision—referred to as the PPACA MLR in this report—differs from the traditional MLR definition. Key differences are that the PPACA MLR allows insurers to include in their expenses spending on activities to improve health care quality and to deduct from their revenues certain tax payments and fees, and these differences will generally increase insurers’ MLRs. Beginning in 2011, PPACA required insurers to meet minimum PPACA MLR standards of 85 percent in the large group market and 80 percent in the small group and individual markets or pay rebates to their enrollees.^{2,3} In implementing these MLR requirements, the Department of Health and Human Services (HHS) includes an adjustment for certain insurers to help address the disproportionate impact of claims variability on smaller health plans. PPACA

¹Pub. L. No. 111-148, §§ 1001(5), 10101(f), 124 Stat. 119, 130, 885 (2010) (inserting and amending a new section 2718 in the Public Health Service Act (PHSA)).

²Generally, small and large group markets refer to coverage sold to a “small employer” or a “large employer.” PPACA generally defines a small employer as having employed an average of 1 to 100 employees and a large employer as having employed an average of 101 or more employees during the preceding calendar year. Until 2016, a state has the option to define small employers as having employed an average of 1 to 50 employees during the preceding calendar year and a large employer as having employed an average of at least 51 employees during the preceding calendar year, in which case that definition will apply in calculating the applicable PPACA MLR standard. See Pub. L. No. 111-148, § 1304(b), 124 Stat. 172.

³Rebates are refunds issued by the insurer to the individual or entity that paid the premium either in the form of a lump sum payment or credit toward premiums.

MLRs for insurers that cover at least 1,000 but less than 75,000 life years (partially credible insurers) will be upwardly adjusted using a credibility adjustment. Insurers that cover 75,000 or more life years (fully credible insurers) will not receive this adjustment.⁴ The PPACA MLR requirements will primarily affect partially and fully credible insurers, which we collectively refer to throughout this report as credible insurers. HHS estimated that in 2011, the PPACA MLR requirements would apply to health insurance plans covering about 75 million insured Americans.

The first set of data subject to the requirements will be for insurer experience for calendar year 2011, which are to be submitted to HHS in June 2012. In the interim, in April 2011, insurers submitted preliminary MLR data to the National Association of Insurance Commissioners (NAIC) based on their 2010 experience using the PPACA MLR definition.⁵ The 2010 MLR data are not subject to the PPACA MLR rebate requirements. In July 2011, we reported that the 2010 data should be considered transitional and may reflect best estimates that will become more precise with data reported for 2011 and future years.⁶ Although these data are transitional, there was interest in early indications of what can be learned from these data given that they are the first data insurers reported using the new PPACA MLR definitions.

You asked us to conduct an analysis of insurers' 2010 MLR data. We addressed two questions: (1) What can be learned from the 2010 MLR data regarding how reported MLR data varied by different insurer characteristics? (2) To what extent did the credibility adjustment, PPACA MLR formula, and reporting requirements affect insurers' 2010 MLRs?

To determine what can be learned regarding how 2010 MLR data varied by insurer characteristics, we analyzed the data reported to NAIC. These included insurers' MLRs that were based on the PPACA MLR formula, as well as data on nonclaims expenses.⁷ Because noncredible insurers were presumed to meet the standards, our analyses were limited to credible insurers. We adjusted the PPACA MLRs to account for the credibility adjustment—throughout this report we refer to these as adjusted PPACA MLRs.⁸ We used the adjusted PPACA MLRs to examine the

⁴Insurers that cover less than 1,000 life years are considered noncredible and presumed to meet the PPACA MLR standards. Life years refers to the total number of months of coverage for all enrollees divided by 12. See 45 C.F.R. § 158.230 (as added by HHS Interim Final Rule, 75 Fed. Reg. 74864, 74927 (Dec. 1, 2010)).

⁵NAIC is the organization of insurance commissioners from the 50 states, the District of Columbia, and the five U.S. territories who regulate the conduct of insurance companies in their respective state or territory. All insurers, with some exceptions, report annual financial statements to NAIC that include data for all health insurance markets offered by an insurer, including MLR data.

⁶GAO, *Private Health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements*, [GAO-11-711](#) (Washington, D.C.: July 29, 2011).

⁷Some insurers operate in multiple markets and multiple states, and a separate PPACA MLR was reported for each insurer, market, and state combination. For the purposes of this report, we use "insurer" to refer to each insurer, market, and state combination.

⁸The credibility adjustment is based on two factors: the size of an insured population and plan deductibles. Because insurers did not report data for deductibles in 2010, our methodology applied a 1.0 multiplier for the deductible adjustment factor for the credibility adjustment. This methodology was based on the assumption that few insurers would have had plans with deductibles greater than \$2,500, the amount at which an insurer would be eligible for a deductible adjustment factor greater than 1, and is consistent with NAIC's approach in a recent report it issued.

percentage of insurers in 2010 that would have met the 2011 PPACA MLR standards and how this varied by market. We examined the data on nonclaims expenses to identify any differences in these expenses by market. We also conducted interviews with insurers as part of our July 2011 report and included information from those interviews in this report. To determine the extent to which the credibility adjustment, PPACA MLR formula, and reporting requirements affected insurers' 2010 MLRs, we analyzed data reported to NAIC in April 2011. The data we examined included premiums and claims, expenses for activities to improve health care quality, and taxes and other fees. We used these data to calculate traditional MLRs for each insurer and then determined the effect that each component of the PPACA MLR formula that differed from the traditional formula and the credibility adjustment had on the adjusted PPACA MLRs. We also examined how the requirement to report at the state level affected the range of MLRs reported by insurers in each market. To assess the reliability of these data, we reviewed relevant documentation, conducted interviews with NAIC officials knowledgeable about the data, and conducted electronic testing of the data to identify obvious errors or outliers. We determined that the data were sufficiently reliable for the purposes of this report.

We conducted this performance audit from August 2011 through October 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results in Brief

We found that most insurers in 2010 would have met or exceeded the 2011 PPACA MLR standards and the impact of various aspects of the PPACA provision varied by market. At least 64 percent of all credible insurers would have met or exceeded the 2011 PPACA MLR standards. A higher percentage of insurers in the large and small group markets met or exceeded the standards compared to those in the individual market. Insurers in the individual market averaged higher nonclaims expenses, including expenses for brokers' commissions and fees, than those in other markets.

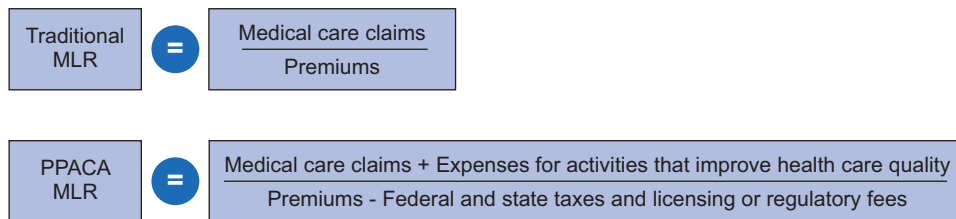
The combined effect of the credibility adjustment and the new components of the PPACA MLR formula resulted in greater increases in average adjusted PPACA MLRs for individual and small group market insurers compared to those in the large group market. The average adjusted PPACA MLRs for individual, small group, and large group market insurers in 2010 were 7.5, 6.5, and 4.8 percentage points higher, respectively, than the average MLRs for these markets calculated without the credibility adjustment and using the traditional MLR formula. In addition, PPACA required insurers to report MLRs by state, and we found a wide range of reported MLRs for multistate insurers.

We provided a draft of this report to HHS and NAIC for comment, and they provided technical comments, which we incorporated as appropriate.

Background

The MLR formula and reporting requirements specified in PPACA differ from the way MLRs have traditionally been calculated and reported. The traditional MLR is generally calculated by dividing an insurer's medical care claims by premiums, whereas the PPACA MLR formula includes additional components to the formula.⁹ (See fig. 1.) Additionally, PPACA included adjustments to the MLR formula and new reporting requirements.

Figure 1: Key Components of Traditional and PPACA MLR Formulas



Source: GAO.

Key components of the PPACA MLR formula, adjustments, and reporting requirements include the following:

- Activities that improve health care quality. These include activities designed to increase the likelihood of desired health outcomes in ways that can be objectively measured, including related health information technology costs.
- Federal and state taxes and licensing or regulatory fees. These include all federal taxes and assessments, excluding taxes on investment income and capital gains.
- Credibility adjustment. To help address the disproportionate impact of claims variability on small health plans, an adjustment to the MLRs is permitted for these plans. Specifically, MLRs for plans with
 - less than 1,000 life years will be considered “noncredible” and will be presumed to meet the MLR requirements;
 - 1,000 to less than 75,000 life years will be considered “partially credible” and will receive a credibility adjustment, which is made up of two factors—a base credibility adjustment factor based on the number of life years and a deductible adjustment factor that further increases the adjustment for plans with high deductibles; and
 - 75,000 life years or more will be considered “fully credible” and will not receive an adjustment.

⁹For the purposes of this report, medical care claims is broadly defined as payments made or anticipated to be made for medical care expenses. For example, medical care claims would include medical care expenses paid, medical care expenses incurred but not yet paid, as well as changes in an insurer's contract reserves. Contract reserves are funds set aside to pay certain claims expected to be incurred in the future.

HHS estimates show that for 2011 a small fraction of insurers that offer plans in the individual, small group, or large group markets would be considered fully credible insurers, but these insurers account for the majority of the total life years covered by these types of plans. About half of the insurers that offer plans in the small and large group markets, and a little less than a third of insurers that offer plans in the individual market, would be partially credible and would apply a credibility adjustment.

- Levels of aggregation for MLR reporting. Insurance companies are required to report MLRs separately for their individual, small group, and large group markets for each state in which they are licensed to operate.¹⁰

PPACA provided HHS with the authority to adjust the MLR standard for the individual market in a state if it determines that the application of the standard may destabilize the individual market in that state.¹¹ HHS's interim final rule implementing PPACA also specified that agents' and brokers' commissions and fees be listed as nonclaims expenses.¹²

In our July 2011 report, we reported on insurers' early experiences in implementing the new PPACA MLR requirements. In that report, we analyzed historical traditional MLR data from NAIC from 2006 through 2009 and found that traditional MLRs on average generally exceeded PPACA MLR standards but varied, particularly among individual market and smaller insurers.¹³ We also interviewed a sample of insurers, and they reported that they expected certain components of the new PPACA MLR formula and reporting requirements to affect their PPACA MLRs compared to traditional MLRs. In addition, insurers told us their 2010 PPACA MLRs may be based in part on best estimates because HHS's interim final rule on PPACA MLRs was published in late 2010, and thus PPACA MLRs may become more precise for 2011 and future years' data.

¹⁰Prior to PPACA, insurers did not report traditional MLRs to NAIC by state.

¹¹See PHSA § 2718(b)(1)(A)(ii) (as added by Pub. L. No. 111-148, §§ 1001(5), 10101(f), 124 Stat. 119,130, 885, 886). As of September 13, 2011, 16 states and 1 territory had applied to HHS for adjustments to lower the PPACA MLR standard for their individual market insurers, and HHS had granted adjustments to 5 of these states, had denied an adjustment to 2 states, advised that in the territory all insurers were noncredible and thus presumed to meet or exceed the statutory standard, and was in the process of reviewing the remaining applications. The 5 states with approved adjustments are Iowa, Kentucky, Maine, New Hampshire, and Nevada, and the approved minimum 2011 PPACA MLR standards for these states ranged from 65 percent to 75 percent.

¹²See 45 C.F.R. § 158.160.

¹³Our prior report did not include an analysis of insurers' 2010 MLR data because at the time of our study, NAIC was in the process of validating insurers' reported data and the data were not fully complete. Additionally, the data included in our prior report were aggregated for each insurer across all of the states in which the insurer operated and reported by market. Beginning in 2010, insurers reported MLR data by market and by state, and throughout this report we use "insurer" to refer to each insurer, market, and state combination. Therefore, the average adjusted PPACA MLRs for 2010 included in this report are not comparable to the average MLRs included in the earlier report.

Most Insurers in 2010 Would Have Met or Exceeded the 2011 PPACA MLR Standards, and Group Market Insurers Had the Highest Average Adjusted PPACA MLRs

In 2010, at least 64 percent of all credible insurers, covering at least 77 percent of lives, would have met or exceeded the 2011 PPACA MLR standards (see table 1).^{14,15} At the market level, a higher percentage of large and small group insurers met or exceeded the 2011 standards compared to individual market insurers. The percentage of insurers in the large and small group markets that met or exceeded the standards were 77 and 70 percent, respectively, compared to 43 percent in the individual market. Because more lives were covered by large and small group market insurers, most covered lives were associated with insurers that would have met or exceeded the standards.

Table 1: Percentage of Credible Insurers and Covered Lives in 2010 That Would Have Been at or above the 2011 PPACA MLR Standards

Market	Total number of credible insurers	Total number of covered lives	Percentage of all covered lives	Percentage at or above the 2011 PPACA standards ^a	
				Percentage of credible insurers	Percentage of covered lives
Individual ^b	553	10,131,103	15	43	48
Small group	601	17,905,130	27	70	76
Large group	642	39,102,236	58	77	85
Total^c	1,796	67,138,469	100	64	77

Source: GAO analysis of NAIC data.

Notes: Data are reported at the state level for each insurer in each market and have been adjusted based on credibility status. The data exclude insurers that were noncredible or for which life years could not be determined to assign credibility status, and insurers that reported negative values for premiums, claims, or number of covered lives. Life years refers to the total number of months of coverage for enrollees divided by 12.

^aAll noncredible insurers are presumed to meet the MLR standards. Including noncredible insurers in this analysis, 84 percent of all insurers, covering 77 percent of lives, would have met or exceeded the standards. In 2010, there were 2,081 noncredible insurers that covered 438,826 lives.

^bThe percentage at or above the 2011 PPACA standards for the individual market accounts for the lower PPACA MLR standards HHS has approved for five states by using the approved minimum 2011 standard for each of these states.

^cSome insurers operate in multiple markets and multiple states. A separate MLR is reported for each insurer, market, and state combination. The total treats each insurer, market, and state combination as a separate insurer.

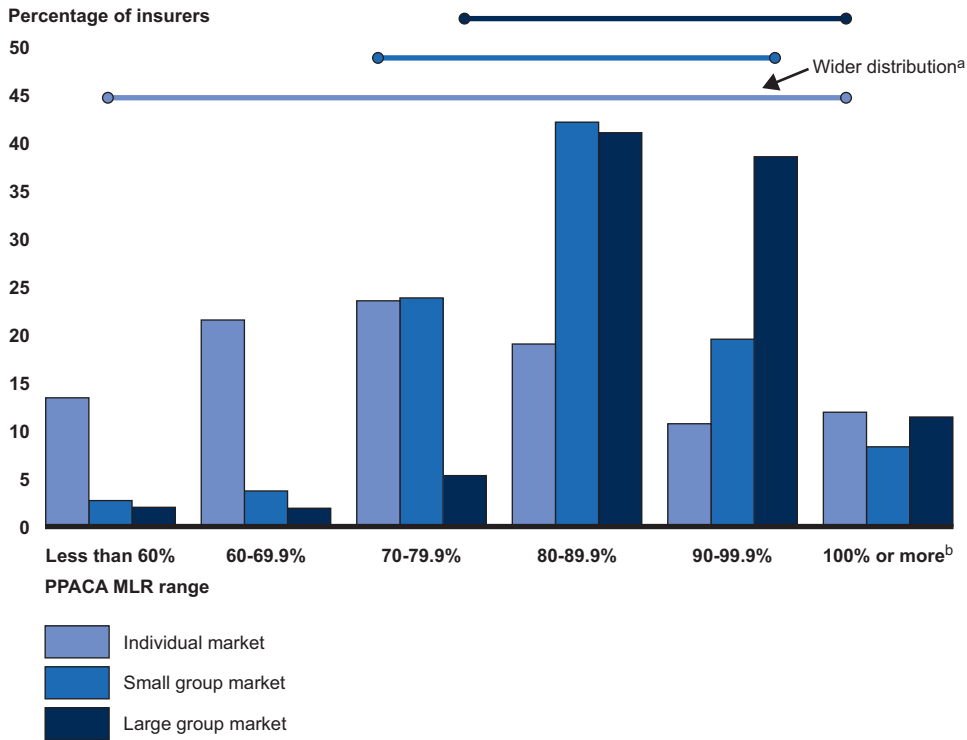
Average adjusted PPACA MLRs were higher in the group markets than in the individual market and were more varied among individual market and smaller insurers. The average adjusted PPACA MLR was 89.5 percent in the large group market, 85.0 percent in the small group market, and 78.8 percent in the individual market. Excluding data for the five states that have been approved for a lower MLR standard in 2011 for the individual market only slightly affected the average adjusted PPACA MLR for this market, increasing it to 79.1 percent. Consistent with our findings in our prior report on traditional MLR data, adjusted PPACA MLRs also varied widely among insurers in 2010. This variation was particularly wide among

¹⁴Covered lives refers to the number of lives insured by a health insurance plan—including the enrollee and any family members also covered by the plan.

¹⁵In addition, all noncredible insurers were presumed to meet the standard.

those in the individual market and among smaller, partially credible insurers (see figs. 2 and 3).

Figure 2: Range of Adjusted PPACA MLRs Reported in the Individual, Small Group, and Large Group Markets, 2010



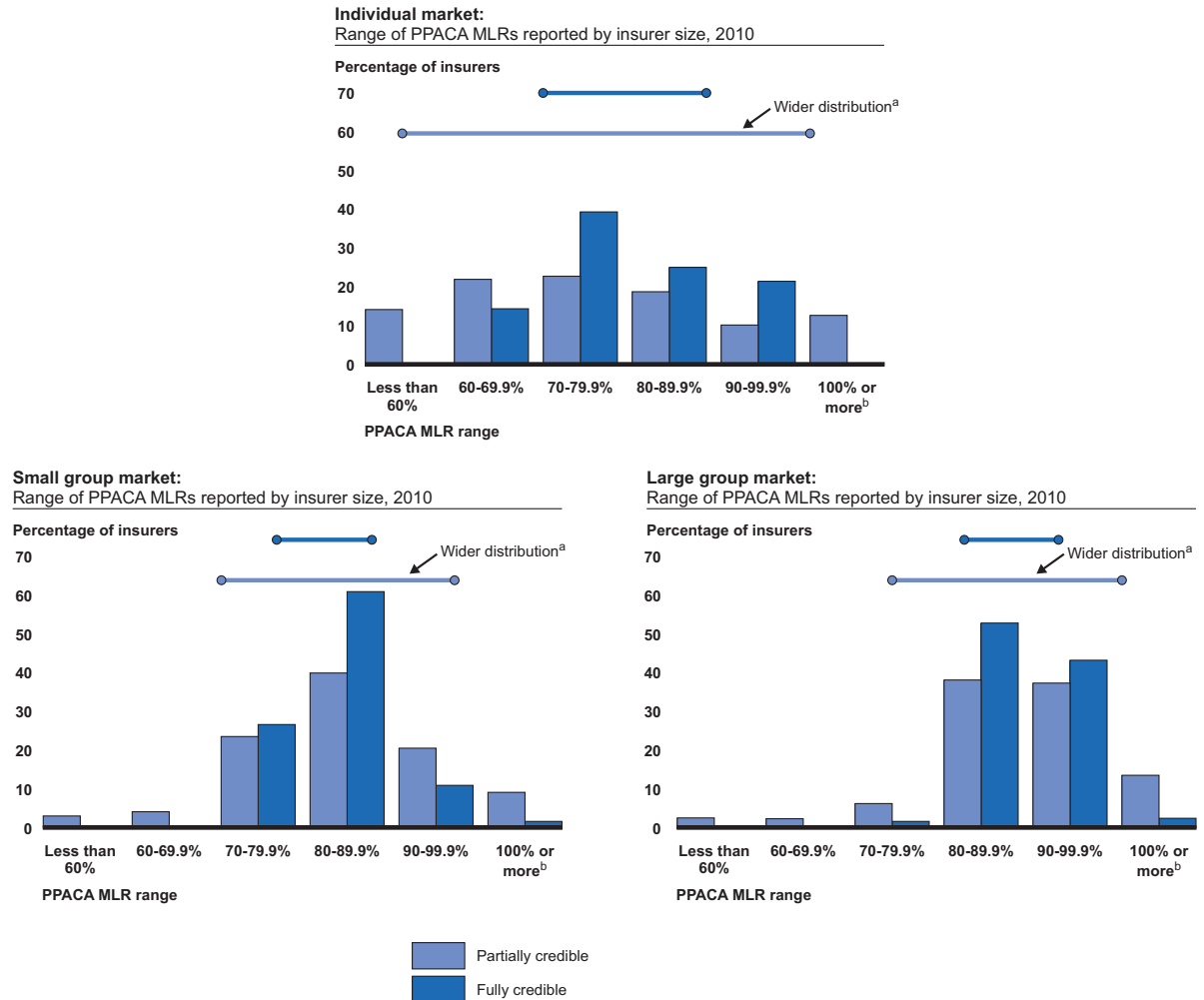
Source: GAO analysis of NAIC data.

Notes: Data are reported at the state level for each insurer in each market and have been adjusted based on credibility status. The data exclude insurers that were noncredible or for which life years could not be determined to assign credibility status, and insurers that reported negative values for premiums, claims, or number of covered lives. Life years refers to the total number of months of coverage for enrollees divided by 12.

^aThe adjusted PPACA MLRs in the individual market were more widely distributed than those in the small and large group markets. The range of one standard deviation below to one standard deviation above the mean adjusted PPACA MLRs was 56.5 to 101.1 percent in the individual market, compared to 71.7 to 98.3 percent in the small group market and 77.6 to 101.4 percent in the large group market.

^bSome insurers reported traditional MLRs above 100 percent indicating that the insurers' claims were greater than the premiums they collected for that year. For example, if an insurer had a small number of enrollees and one enrollee had an extremely large claim then the result could be an MLR over 100 percent.

Figure 3: Range of Adjusted PPACA MLRs Reported in the Individual, Small Group, and Large Group Markets, by Credibility Status, 2010



Source: GAO analysis of NAIC data.

Notes: Data are reported at the state level for each insurer in each market and have been adjusted based on credibility status. The data exclude insurers that were noncredible or for which life years could not be determined to assign credibility status, and insurers that reported negative values for premiums, claims, or number of covered lives. Life years refers to the total number of months of coverage for enrollees divided by 12.

^aThe adjusted PPACA MLRs among partially credible insurers were more widely distributed than larger insurers in all markets. In the individual market, the range of one standard deviation below to one standard deviation above the mean adjusted PPACA MLRs was 56.0 to 101.6 percent for insurers that would have been partially credible, and 71.0 to 89.8 percent for insurers that would have been fully credible. In the small group market, the range was 71.3 to 99.1 percent for partially credible insurers and 77.6 to 89.4 percent for fully credible insurers. In the large group market, the range was 76.4 to 102.6 for partially credible insurers and 84.4 to 94.8 percent for fully credible insurers.

^bSome insurers reported traditional MLRs above 100 percent indicating that the insurers' claims were greater than the premiums they collected for that year. For example, if an insurer had a small number of enrollees and one enrollee had an extremely large claim then the result could be an MLR over 100 percent.

One factor that might contribute to higher average adjusted PPACA MLRs in the group markets is that these insurers spent less on nonclaims expenses than insurers in the individual market.¹⁶ On average, total nonclaims expenses represented 13 percent and 16 percent of premiums earned in the large and small group markets, respectively, compared to 23 percent in the individual market. Within the nonclaims expenses, insurers in the large and small group markets averaged lower expenses for brokers' fees and commissions as a percentage of premiums earned (3 and 5 percent respectively) than insurers in the individual market (7 percent).

The 2010 data for insurers are transitional and may not be fully reflective of the data that will be reported in 2011. For example, almost 11 percent of insurers in all three markets combined did not report any expenses to improve health care quality. However, the absence of these data does not necessarily mean that the insurers did not incur these expenses. One insurer that we interviewed told us that while they had expenses for quality improvement for the individual market, they did not have enough information to report these expenses for 2010 since this was a new reporting requirement. This insurer said that they will collect and report this information for 2011.¹⁷ Other factors that may affect data reported in 2011 are differences in how the 2010 NAIC data were reported compared to how they will be reported to HHS for 2011 under PPACA. Some of these differences include adjustments to federal income tax deductions as a result of any rebates owed for not meeting the PPACA MLR standards and the inclusion of claims runoff (claims incurred in the reporting year but not paid up until March 31 of the following year). It is unclear what the net impact of these differences will be on PPACA MLRs in 2011 and beyond.

The Adjustment and the PPACA MLR Formula Most Affected Individual and Small Group Insurers; Using the New Reporting Requirements, Multistate Insurers Reported a Wide Range of MLRs

The combined effect of the credibility adjustment and the new components of the PPACA MLR formula resulted in greater increases in average adjusted PPACA MLRs for individual and small group market insurers compared to those for insurers in the large group market. The average adjusted PPACA MLRs for individual and small group market insurers in 2010 were 7.5 and 6.5 percentage points higher, respectively, than the average MLRs for these markets calculated without the credibility adjustment and using the traditional MLR formula. For the large group market, the percentage point increase was 4.8. (See table 2.) For each market, the credibility adjustment—which is applied only to insurers that are considered partially credible—accounted for the largest percentage point increase on the average adjusted PPACA MLRs. The percentage point increases for this adjustment ranged from 4.2 in the individual market to 2.7 in the large group market.

¹⁶Nonclaims expenses are those that are not related to medical care or expenses to improve health care quality. Examples include sales expenses, brokers' fees and commissions, cost containment expenses, and other general and administrative expenses.

¹⁷Insurers also said that their 2010 MLR data will not be as precise as their MLR data for 2011 and beyond when MLRs are subject to the PPACA MLR requirements. For example, some insurers said that they used their best estimates to report their expenses to improve health care quality for 2010.

Table 2: Effect of the Credibility Adjustment and New Components of the PPACA MLR Formula on Average Adjusted PPACA MLRs by Market, 2010

Credibility adjustment and PPACA MLR components	Percentage point increase		
	Individual market	Small group market	Large group market
Credibility adjustment	4.2	3.3	2.7
Total of components of formula	3.3	3.2	2.2
<i>Federal and state taxes and regulatory fees</i>	2.6	2.3	1.3
<i>Expenses to improve health care quality</i>	0.5	0.7	0.8
<i>All other components^a</i>	0.2	0.1	0.1
Total of credibility adjustment and components	7.5	6.5	4.8

Source: GAO analysis of NAIC data.

Notes: Data are reported at the state level for each insurer in each market and have been adjusted based on credibility status. The data exclude insurers that were noncredible or for which life years could not be determined to assign credibility status, and insurers that reported negative values for premiums, claims, or number of covered lives. Life years refers to the total number of months of coverage for enrollees divided by 12. Percentage points may not add to totals because of rounding.

^aAll other components included federal and state high-risk pools and fraud and abuse detection and recovery expenses.

Among the new components included in the PPACA MLR formula, the deduction of taxes and fees in the denominator accounted for the largest increase in all markets. The deduction of taxes and fees resulted in percentage point increases in the average adjusted PPACA MLRs of 2.6 in the individual market, 2.3 in the small group market, and 1.3 in the large group market. The addition of expenses to improve health care quality in the numerator of the PPACA MLR formula had the next largest effect on insurers' 2010 MLRs. The average increases that were due to components of the PPACA MLR formula are consistent with what insurers told us.¹⁸ Other components in the PPACA MLR formula, including fraud and abuse detection and recovery expenses, had less of an effect on insurers' 2010 average adjusted PPACA MLRs.

Using the new PPACA MLR reporting requirements, many of the insurers that operated in multiple states in 2010 reported a wide range of adjusted PPACA MLRs across states. For example, one insurer that operated in over 20 states in the individual market had adjusted PPACA MLRs in that market ranging from 50 percent to 94 percent. However, when aggregated by all of the states in which this insurer operated, as the historical traditional MLR was generally reported, this insurer had an adjusted PPACA MLR for the individual market of 72 percent. Wide ranges of adjusted PPACA MLRs also existed for many insurers that only operated in two states. For example, one insurer in the small group market had an adjusted PPACA MLR of 66 percent in one state and 103 percent in the other state, with an adjusted PPACA MLR of 84 percent for both states combined. This is consistent with what insurers told us, that the PPACA MLR requirements to report MLRs by market and by each state in which insurers operate would result in variation in their MLRs.

¹⁸The insurers we interviewed said their PPACA MLRs will be affected by changes in the MLR formula, primarily due to the deduction of taxes and fees in the denominator, and to a lesser extent, the addition of expenses for activities to improve health care quality in the numerator.

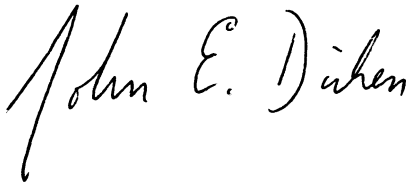
Agency and Third-Party Comments

We obtained written comments from HHS, which are reprinted in enclosure I. HHS commented that the PPACA MLR provision will make the insurance marketplace more transparent and make it easier for consumers to determine which plans provide better value for their money. HHS also provided technical comments, which we incorporated as appropriate.

Additionally, we provided a draft of this report to NAIC for comment. NAIC provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and appropriate congressional committees. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in enclosure II.



John E. Dicken
Director, Health Care

Enclosures - 2

Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

John Dicken, Director
Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

OCT 11 2011

Dear Mr. Dicken:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "Private Health Insurance: Early Indicators Show that Most Insurers Would Have Met or Exceeded New Medical Loss Ratio Standards" (GAO-12-90).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "PRIVATE HEALTH INSURANCE: EARLY INDICATORS SHOW THAT MOST INSURERS WOULD HAVE MET OR EXCEEDED NEW MEDICAL LOSS RATIO STANDARDS" (GAO-12-90)

The Department appreciates the opportunity to review and comment on this draft report.

The medical loss ratio provisions are one of the key changes included in the Affordable Care Act that will make the insurance marketplace more transparent and make it easier for consumers to determine which plans provide better value for their money. Prior to these changes, many insurance companies spent a substantial portion of consumers' premium dollars on administrative costs and profits, including executive salaries, overhead, and marketing. The medical loss ratio regulations will help ensure that consumers receive more value for their premium dollar because insurance companies will be required to spend 80 or 85 percent of premium dollars on direct medical care and quality improvement, rather than on administrative costs. Insurance companies spending less than this will be required to provide a rebate to their customers starting in 2012. The medical loss ratio rules also ensure that the health insurance marketplace is more transparent to consumers. Starting in 2012, insurance companies will begin reporting premium and expenditure information in each state in which they do business. This information will be publicly available so consumers will be able to evaluate the value of their insurance plan and see how it compares to other plans offered in their area.

Enclosure II

GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or dickenj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Gerardine Brennan, Assistant Director; George Bogart; Julianne Flowers; Drew Long; Lisa A. Lusk; and Janet L. Sparks made key contributions to this report.

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