



June 7, 2010

Mr. Lou Felice
Chair, Health Reform Solvency Impact Subgroup

Mr. Todd Sells
Director, Financial Regulatory Services

Dear Mr. Felice and Mr. Sells,

Families USA is a nonprofit, nonpartisan consumer advocacy organization dedicated to the achievement of high-quality, affordable health care for all Americans. We appreciate the opportunity to provide comments as an interested party to the National Association of Insurance Commissioners (NAIC) Health Reform Solvency (E) Subgroup as it works to ensure strong definitions for the medical loss ratio (MLR) requirements included in the Patient Protection and Affordable Care Act (PPACA).

In particular, we would like to provide input as the subgroup prepares recommendations for the Secretary of Health and Human Services (HHS) regarding the definition of “activities that improve health care quality.” Specifically, we encourage the NAIC to take great care to ensure that quality improvement expenses are not defined too broadly as to provide a loophole for insurers to artificially meet MLR requirements. We urge the NAIC to recommend to the Secretary a set of criteria to evaluate the activities that insurers propose to count towards quality improvement expenses in order to ensure that they are classified appropriately in the MLR calculation:

First, we believe that any activities that are classified as quality improvement expenses should be evidence-based and that innovative programs should be required to demonstrate their effectiveness. We are aware that the NAIC is currently debating whether insurers must present evidence of effectiveness or outcomes data in order to count an activity as a quality improvement expense. Families USA believes that activities included as quality expenses should have empirical evidence of direct effectiveness in improving quality. Research bodies from entities such as the Agency for Healthcare Research and Quality can serve as a guide to determine which activities are supported by evidence and which have effects on quality that are unsubstantiated. If insurers want to implement innovative quality improvement ideas for which an evidence base does not yet exist and count the costs of those efforts as quality expenses, we believe that they should be required to substantiate, with outcomes data, the positive results of their expenditures on such new activities. If innovative programs do not demonstrate a positive effect on enrollees’ quality of care over a given time period (for example, three years), the expenses should no longer be included on the medical side of the MLR calculation.

Second, Families USA recommends that the NAIC ensure that any activities claimed as quality expenses primarily serve the purpose of improving the quality of care that enrollees receive and do not only lower costs for the insurer or the enrollee. Activities that insurers perform primarily to lower costs and that they would not perform were not it for cost reductions should not be included on the medical side of the MLR equation. We recognize that some of these activities, such as fraud and abuse prevention efforts, may improve the quality of care indirectly and that insurers are urging the NAIC to include them as quality expenses in the MLR calculation. However, reducing costs does not always equate to improved quality, and can sometimes actually have a negative effect on the quality of care that enrollees receive. Specifically, insurers may wish to include functions like “utilization review,” “medical necessity review,” or “medical management” as quality expenses. However, these terms are frequently used to describe processes that exist as a way for insurers to deny services to enrollees— services ordered and considered necessary by their personal physicians. We believe that the NAIC should recommend that the Secretary does not allow these functions, which are primarily used to minimize insurers’ claim burdens, to count as quality expenses in MLR calculations under PPACA. Further, we are aware that the NAIC is debating how to account for HIT costs in MLR calculations. In determining a recommendation for the classification of HIT costs, we believe that the NAIC should assess the amount of HIT spending by insurers (as opposed to that by providers or medical facilities) that is actually relevant to quality improvement. Only activities that serve a primary purpose of improving the quality of care that enrollees receive should count towards quality expenses.

Third, current required costs of doing business as an insurer should not be included in the category of expenses that improve health care quality. We are aware that insurers are urging the NAIC to include activities that they perform in order to meet standards for operating, such as provider credentialing or the use of certain coding or billing systems, in the quality improvement category of the MLR. However, these costs of ensuring that a health plan is adequate to operate are not expended for the primary purpose of improving health care quality for enrollees and therefore Families USA recommends that the NAIC does not include them in its proposed definition of quality improvement expenses.

Fourth, grant funding or other funding separate from premium revenues that insurers receive or utilize to implement quality initiatives should not be included in the MLR calculation. Quality improvement expenses paid with external funding, such as that from the federal government, states, foundations, or other entities, should not count as quality expenses in the numerator of the MLR calculation. Expenses paid through other sources do not reflect how a plan is using enrollees’ premium dollars. Therefore, we urge the NAIC to ensure that they are not included insurers’ MLR calculations, which are intended by PPACA to serve as a measure of the value that consumers receive for their premium dollars.

Fifth, safeguards must be in place to ensure that expenses are not double-counted in the MLR calculation.

The way that quality expenses are classified must include safeguards to protect against the double-counting of expenses in both the quality and the medical cost categories. For example, if a staff-model HMO invests in quality-improving health information technology (HIT) for its

provider offices and increases provider rates to account for this expense (a medical cost in the MLR equation), it should not also count such HIT spending in the quality-improvement category of the equation.

The Blanks proposal for the Supplemental Health Care Exhibit of the NAIC Annual Statement excludes community benefit expenses in lieu of premium taxes from earned premiums in the denominator of the MLR equation. Under this exclusion, we believe that there must be a way to ensure that any community benefit expenses used for quality improvement are not also counted in the numerator of the equation as quality expenses. To this end and in the interest of transparency, it would be helpful if community benefit expenses were listed separately from state and local taxes in the Supplemental Health Care Exhibit. There must also be safeguards to protect against the double-counting of shared savings or incentive payments to providers to promote quality so that the same expenses are not recorded as both “incurred medical incentive pools and bonuses” and quality improvement expenses in the Supplemental Health Care Exhibit.

Members of Congress have expressed concern that the inclusion of quality improvement activities in MLR calculations, if not defined appropriately, may provide an opening for insurers to evade the robust requirements they intended in PPACA.¹ By recommending a narrow definition of activities that improve health care quality for the purpose of the MLR requirements in PPACA, the NAIC can help to ensure that Congress’ intent of providing high-value, high-quality coverage at an affordable cost is achieved.

Thank you for considering our comments. If you have any questions, please do not hesitate to contact Claire McAndrew at cmcandrew@familiesusa.org or at 202-628-3030.

Sincerely,

Claire McAndrew
Health Policy Analyst

¹ United States Senate Committee on Commerce, Science, and Transportation, *Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers*, (Washington: Committee on Commerce, Science, and Transportation, April 14, 2010); Congressman John F. Tierney, et.al., *Letter to Secretary Kathleen Sebelius* (Washington: United States House of Representatives, April 26, 2010); Congressman John D. Rockefeller, *Letter to Secretary Kathleen Sebelius* (Washington: United States Senate, May 7, 2010).