

June 21, 2010

Mr. Lou Felice, Chair
Health Reform Solvency Impact (E) Subgroup
c/o National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

RE: NAIC Life and Accident & Health Blank and SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3. (Post-June 17th Health Care Solvency Impact E Subgroup Call)

VIA ELECTRONIC MAIL

Dear Mr. Felice:

Your Consumer Representatives to the NAIC, representing millions of patients, consumers and workers, are writing to follow-up with you in writing after the June 17th call to offer some additional comments and observations on the benefit of segregating shared savings from incentive payments, loss adjusted expenses, accounting for agent/broker commissions, applicable provisions contained in Section 3011, definitional issues around the use of specific populations, the removal of the Secretary's discretion to define "other expenses", and continuing concerns regarding the broad inclusion of ICD-10 expenses. These comments are in addition to and complement the comments we offered on June 14th on the 2010 NAIC Life and Accident & Health Blank June 10, 2010 Discussion Draft (NAIC Blank) and our first comment letter dated May 20, 2010.

Medical Incentive Pools and Bonuses

We understand that the Subgroup has not accepted our position on line 3 of the blank proposal, on which incurred medical incentive pools and bonuses are reported. Our concern continues to be that, although incentive payments to promote quality improvement may be recognizable as "activities that improve health care quality," shared savings programs under which providers are paid for not providing care should not be classified as "reimbursement for clinical services provided to enrollees." Programs that incentivize providers to provide fewer services to enrollees should properly be classified as administrative expenses. In any event, they should be separately reported on the blank in the interests of transparency and accountability so that regulators and consumers can understand how much insurers are spending for these purposes.

Loss Adjusted Expenses

We continue to support the position that both the Health Reform Solvency Impact (E) Subgroup and the PPACA Actuarial Subgroup of the AHWG (IRD001) have adopted that loss adjustment expenses are not included in the 2718(b) rebate formula. This position is based on the plain language of the statute, which requires the disclosure of loss adjustment expenses under 2718(a), but does not include them in the rebate formula in

2718(b). This is only one of several differences between the 2718(a) disclosure formulas and the 2718(b) rebate formula. The position is also supported by correspondence the NAIC received from two of the key Senate supporters of the legislation. The fact that two law firms retained by insurers disagree with this position does not undermine the determination that the subgroups have made. To the extent that this position creates an unlevel playing field between HMOs and PPOs, the issue should be resolved by requiring HMOs to identify their loss adjustment expenses as administrative costs and not claiming them as “reimbursement for clinical services.”

Agent/Broker Commissions

An objection was raised last week by Cigna to agent/broker commissions being counted as part of premiums for the MLR denominator and as administrative expenses for the MLR numerator. Cigna argued that commissions should be excluded from both. This position is surprising, as the industry has consistently argued that the historically high cost of agent/broker commissions as a primary reason why a transition is needed to the statutory MLRs to avoid destabilization of the market. It is clear, however, that Congress intended agent/broker commissions to be counted as administrative costs for purposes of the MLR. On December 20, 2009, hours before the Senate passed PPACA, Senator Nelson, the former insurance commissioner of Florida, explaining how the legislation made health insurance more affordable, stated on the Senate floor:

I want to give one specific example. It is a technical term in the insurance industry called the “medical loss ratio.” It is the ratio in what an insurance company actually pays out in medical claims as opposed to what it pays for administrative expenses such as marketing, insurance agent commissions, underwriting, and an insurance company's profit. . . . What this amendment, . . . says, is it causes a specific ratio so you are getting a high amount of return on the insurance premium dollar. . . . And the balance, . . . is going to things such as administrative expenses, paying for insurance agents, commissions, paying for their profit. . .

155 Cong. Rec. S13558, S13626-S13627

Section 1301(a)(1)(C)(iii) of PPACA, states that the issuer of a qualified health plan must agree “to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent.” Obviously Congress understood that agent/broker commissions were part of the premium rate charged by health insurers. We support the Subgroup in maintaining this position.

Section 3011

The Solvency Impact Subgroup has properly focused on section 2717 as the primary provision of PPACA dealing with the responsibilities of health plans for quality of care. Section 1311(g), which addresses the payment strategies that qualified health plans are encouraged to pursue to improve quality lists similar quality of care factors and could also be seen as relevant to 2718. Section 3011, however, addresses a much broader topic, “a national strategy to improve the delivery of health care services, patient health outcomes, and population health,” and is not relevant to 2718, which only considers

“activities [of insurers] that improve health care quality.” Section 3011 focuses heavily on efficiency. While efficiency is important, it is not a factor in the 2718(b) formula. The listing of efficiency (and transparency) as a factor in the proposed revised general definition is, therefore, inconsistent with section 2718.

Specific Populations

We are generally supportive of the addition of specified populations and appreciate the concerns you expressed regarding offering an adequate definition of specified populations that is attributable back to the enrollees in the specific health plan. We would encourage and support a definition that would take into a consideration a targeted segment of enrollees and a broader general population where the plan has a significant market share when it is supported by the evidence-base and justified to reach their covered lives through population-level quality interventions.

You had also inquired about examples of community-level quality interventions that would be directed towards specified populations. There is a strong and growing evidence base for community-level quality initiatives and we would encourage you to hold these quality expenses to the same rigor as the Blanks Discussion Draft has established for quality initiatives directed at the individual (evidence based, focus on quality improvement and not cost containment, etc). We believe that in addition to the specific community-level interventions recommendations contained in the Community Guide (<http://www.thecommunityguide.org/>), you would similarly want to allow other quality initiatives that have a strong theoretical bases for intervening at the community level to achieved the desired results. As with individual quality initiatives, health plans must monitor and evaluate these interventions and periodically report on whether they are achieving their intended quality outcomes. The burden should be on the plan to demonstrate the above in a transparent manner. In addition to the examples offered on the June 17th call (infection control), we would also suggest that investments in improving underdeveloped emergency medical response systems (trauma, stroke, heart attacks and cardiac arrest, burn treatment) is another compelling example when overall care can only be achieved at the population level to benefit individual enrollees.

Role of the Secretary of Health and Human Services

While we appreciate and continue to vigorously support a “high bar” threshold for other expenses to be deemed quality improvement (objectively measured, verifiable, achieve desired health outcomes, burden of proof on proponent of additional expenses), we were unconvinced by the rationale offered for eliminating the discretion of the Secretary of Health and Human Services (in consultation with the NAIC) to approve any new such expenses. Our reading of this revision and the resulting language in the current discussion blank is silence on where the decision-making and authority resides to make such determinations. We are concerned that the consequences of such open-ended provision would lead to unclear roles and responsibilities of proponents, NAIC and individual commissioners; a diminished standard of what is required to demonstrate quality improvement; and a lack of public notice and transparency with regard to the process to make these determinations. We would encourage additional dialogue between the NAIC and HHS to ascertain the appropriate role for the Secretary in this regard and

until such time that further guidance and direction is received, we would strongly recommend the restoration of the Secretary's authority in this section.

ICD-10 Expenses

We continue to believe that all cost directly relating to ICD-10 be considered an administrative expense. While not specifically addressed and resolved on the June 14th call, our impression is that there is some consideration being given to include ICD-10 expenses as quality initiatives. We acknowledge that ICD-10 will facilitate better tracking of important metrics such as outcomes, severity, medical complications and safety issues. And while these metrics are important to monitor and evaluate quality initiatives, the primary purpose of ICD-10-CM and ICD-10-PCS remains payment coding. So unless there is an objectives means and formula to attribute a portion of these expenses to be considered quality improvement (which we are not aware of), we would continue to recommend that all ICD-10 costs continue to be defined as administrative expenses.

We appreciate this opportunity to submit additional comments after the June 17th call and look forward to the continued opportunity to be actively engaged in the deliberations of the Health Reform Solvency Impact (E) Subgroup this week as you work to finalize the Blank instructions. If you have any questions, please contact Timothy Jost at JostT@wlu.edu or Mark Schoeberl at mark.schoeberl@heart.org .

Sincerely,

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