

June 28, 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 24th 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 24th call to provide our comments and recommendation regarding the proposed and alternative language for Improving Health Care Quality Expenses distributed at the June 24th conference call. We would also like to reiterate our positions on several other provisions discussed during the call including Sections 1311 and 1301, 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 17th and 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. At your request, we are also attaching an additional document to this comment letter that offers specific edits in the current discussion draft.

Supplemental Health Care Exhibit – PART 3 Improving Health Care Quality Expenses – General Definition

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.

Agent/Broker Commissions

Congress intended agent/broker commissions to be counted as administrative costs for purposes of the MLR. 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.

Sections 1311 and 3011

We continue to support exclusion of Section 3011 from General Definition of Improving Health Care Quality Expenses. 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) 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.

Specific Populations

We continue to be generally supportive of the addition of specified populations and appreciate the concerns expressed regarding an adequate definition of specified populations that is attributable back to the enrollees in the specific health plan. Further development of a standard definition or methodology and rationale that could be used by all insurers to demonstrate the value of including the health care initiatives involving specified populations and individuals that are not enrolled in the health plan as an allowable expense would be useful to insurers, consumers and regulators. It would also provide more transparency about the programs and their value as partnerships with employers, providers, hospitals, community programs or state health initiatives.

We believe that it is not reasonable to expect the individual, small and large employer fully insured plans to cover all the costs of ‘community benefit’ activities for specified populations. Self-funded health plans that contract with carriers through administrative services only (ASO) contracts are not included in the MLR calculation. The insurer’s self-funded plans should cover their fair share of the cost of “community benefit” activities, too. If these activities are going to be allowable expenses, the fully insured plans should only cover their fair share of the expenses.

Therefore, we support retaining the existing language, but would like to propose the modifications included in the attached document to assure that the expenses related to individuals and populations that are not enrollees of the insurance plan are fairly allocated across the carrier’s entire covered lives. We also want to stress the importance of making QI information available to consumers and the general public to provide transparency and ensure that these expenses are ultimately benefiting individual enrollees and/or segments of the enrolled population.

Role of the Secretary of Health and Human Services

While we believe the current definition provides more transparency and accountability for Health Care Quality expenses than previous iterations, we continue to believe that is essential to retain an appropriate oversight role of the HHS Secretary in certifying the QI

activities. We recognize and appreciate the concerns expressed regarding HHS's resources to implement this requirement and the potential for the certification process becoming either a rubber stamp or causing a log jam in the approval of legitimate innovative new programs. One of the goals of the law is to be able to compare the quality activities to promote health outcomes, improve patient safety and reduce medical errors. The HHS Secretary can use the expense information and outcomes generated by the process of certifying quality health care activities to compare the performance and value of the insurance coverage provided by the various insurers. We continue to believe the HHS Secretary's responsibilities play a key role in protecting consumers.

So while we remain open to recommendations that could streamline the certification process or give "deem" status to activities that have been approved by the Secretary for one insurer in the event that another insurer wants to implement the same activity, we would strongly recommend retaining the Secretary's authority in this section and encourage additional dialogue between the NAIC and HHS to ascertain the appropriate role for the Secretary, the NAIC and state insurance commissioners. We also continue to be concerned about the impact of a diminished standard on what is required to demonstrate quality improvement and the lack of public notice and transparency with regard to the process to make these determinations.

ICD-10 Expenses

We continue to believe that all costs directly relating to ICD-10 should be considered an administrative expense. We acknowledge that ICD-10 includes standardization of certain clinical codes and clinical values that will facilitate better tracking and reporting of clinical information in the patient's electronic medical record and 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 claims processing which is a core competency of an insurer. So unless there is an objective means and formula to attribute a portion of these expenses to be considered quality improvement (which we are not aware of), we continue to recommend all ICD-10 costs be defined as administrative expenses.

Accreditation Expenses

General accreditation expenses, and all Quality Assurance (QA) program costs, should be considered administrative costs. We believe that Section 2718(b) only allows the costs of activities that improve quality of health care, and not activities that assure the quality of health insurance, to be considered. Health plans have and we believe will continue to seek accreditation to secure a competitive advantage in the marketplace and to meet state quality regulations that are required as a condition of licensure. We do, however, continue to support the inclusion of distinct QI activities that may be a part of the accreditation process as long as they meet the established definitions.

Attribution of Cost Containment Expenses

Finally, we want to vigorously reinforce and stress our previous comments that costs associated with cost containment and cost control initiatives must be excluded. We envision great definitional difficulties with determining what are "primarily attributable"

and “solely attributable” costs and perhaps more convincingly, the tremendous practical challenge of uniformly interpreting and enforcing any definition that attempts to objectively segment and quantify a subset of cost containment expenses that may arguably have some downstream impact on quality of care.

We appreciate this opportunity to submit additional comments after the June 24th 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,

Mark Schoeberl
Timothy Jost
Wendell Potter
Stephen Finan

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3

[NAIC Consumer Representative Comments]

Part A of this exhibit is intended to provide disclosure of expenses by major type of activity that improves health care quality, as defined below, as well as the amount of those expenses that is used for other activities, and reported separately for the Individual, Small Group and Large Group amounts. Part B of this exhibit is intended to show the amount of qualifying HIT expenses, reported separately for the Individual, Small Group and Large Group amounts, broken down into the four categories of Quality Improvement expenses (see below); similarly, the Other than HIT qualifying Quality Improvement expenses are disclosed for each of the four categories of Quality Improvement expenses. The definitions of Individual, Small Group and Large Group are found in the instructions for Parts 1 and 2 of this supplemental exhibit.

Improving Health Care Quality Expenses – General Definition:

Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for health services that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and which produce verifiable results and achievements. The expenses must be directed toward ~~for~~ individual enrollees or ~~costs may be~~ incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage. ~~as long as no additional costs are incurred due to the non-enrollees.~~ **Non-enrolled specified populations may include potential enrollees; a definable community reached by essential community providers and/or public health entities, or the general public. The portion of the carrier's expenses for developing and implementing activities that benefit common non-enrolled populations shall be prorated between the fully insured and self-funded business of the carrier.** *[industry to provide language and comments]*, that are designed to increase the likelihood of desired health outcomes, and that are **Qualifying QI expenses should be** 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 organizations. They should not be designed primarily to control or contain cost, ~~and the improvement must be capable of being objectively measured and produce verifiable results and achievements.~~ Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSa and Section 1311 of the PPACA; ~~improvement must be capable of being objectively measured and produce results and achievements that can be verified to:~~

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates;
- Increase wellness and promote health activities; or
- Enhance the use of health care data to improve quality, transparency, and outcomes.

[Comments about transparency?]

To ensure that expenses are being objectively measured and achieving verifiable quality improvement for enrollees or segments of enrollees, a detailed description of these metrics and results must be included in the supplemental filing made by the insurer providing descriptions of the method utilized to allocate QI expenses to each State and to each line and column on Part 3. This information shall be released annually and available to consumers and the general public at any time upon request.

NOTE: Expenses which otherwise meet the definitions for QI but which were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.

COLUMNS:

Expense Allocation: A separate, regulator only supplemental filing must be made by the insurer to provide a description of the method utilized to allocate QI expenses to each State and to each line and column on Part 3. Additionally, companies reporting QI expenses in columns 1 through 5 must include a detailed description of such expense elements, including how the specific expenses meet the definitions above. For a **new initiative** that otherwise meets the definition of QI above but has not yet met the objective, verifiable results requirement, include an “X” in the “New” column of the supplement and include in the **detailed** description the **QI activity including rationale,** expected timeframe for the activity to accomplish, **and** the objective, verifiable healthcare quality improvement **to be achieved and metrics that will measure results.** These will be reviewed for adherence to the definition and standards of QI and may be specifically incorporated into, or excluded from, the instructions for QI for future reporting purposes. **As part of this review for adherence, these metrics and results must be included in subsequent filing made by the insurer and available to consumers, organizations representing consumers and the general public.**

The following items are broadly excluded as not meeting the criteria of this section:

- 24 Hour Medical Professional Hotlines (except as noted above);
- Utilization Review;
- Fraud Prevention activities;
- Network Management;
- Provider Contracting;
- Accreditation Fees **[Available for comments]**;
- Costs associated with calculating and administering individual enrollee or employee incentives. This includes rewards or bonuses associated with wellness or health promotion programs (e.g., reductions in individual enrollee or group health plan copays, deductibles or premiums based on achieving specified health outcomes or engaging in specified health promotion activities); and
- Any function not expressly included in Columns 1 through 5.

[see NAIC Consumer letter dated June 28th, 2010 for additional comments on alternative approach]