April 30, 2010

Lou Felice  
Chair, Health Care Reform Solvency Impact Subgroup

Steven Ostlund  
Chair, Accident & Health Working Group

Re: Application of Medical Loss Ratio Requirements to Limited Benefits Plans

Dear Mr. Felice and Mr. Ostlund:

We are writing to comment on the implementation of Medical Loss Ratio (MLR) requirements contained in the Public Health Service Act (PHSA), as added by the Patient Protection and Affordable Care Act (PPACA). This issue is of critical importance to American Specialty Health and other limited benefits plans.

Summary

American Specialty Health, Incorporated and its family of companies (ASH) is a leading provider of specialty network management, and prevention and wellness services. As NAIC considers how to implement the MLR requirements in PPACA, it is critical that these requirements not apply to limited benefits plans such as those offered by ASH. The nature of limited benefits plans results in a systematically lower MLR, and states have historically not required limited benefits plans to comply with the MLR requirements applicable to comprehensive plans. We urge NAIC to recommend that the Department of Health and Human Service (HHS) make clear that the MLR requirements do not apply to limited benefits plans.

American Specialty Health’s Business

American Specialty Health is among the nation’s leading health improvement and wellness organizations. ASH provides specialty network management, prevention & health programs including health coaching, and fitness programs to health plans, insurers, and employer groups. In its specialty network management programs, ASH provides complementary health care services including chiropractic, acupuncture, naturopathy, dietetic counseling, and occupational, physical and massage therapy. ASH provides evidence-based services in a cost-effective manner. ASH does not provide comprehensive medical insurance—all of the benefits provided by ASH are classified by NAIC as limited benefits.¹

¹ NAIC has defined a “Limited Benefits Plan” as a “type of health plan that provides coverage for only certain specified health care services or treatments or provides coverage for health care services or treatments for a certain amount during a specified period.” NAIC Glossary of Health Insurance Terms, April 2010.
ASH provides benefits to members through various affiliated companies including the following:

- **American Specialty Health Insurance Company (ASHIC)** —a limited benefits insurer licensed in 43 states and the District of Columbia. ASHIC contracts primarily with large employer groups and offers benefit options limited to chiropractic, acupuncture, massage therapy, dietetic counseling and/or naturopathic services.

- **American Specialty Health Plans of California, Inc. (ASHP)** —a specialty health plan licensed as a specialized health care services plan by the California Department of Managed Health Care. ASHP contracts with both small and large employer groups in California and offers benefits limited to chiropractic and/or acupuncture services.

**PPACA’s MLR Requirements Should Not Apply to Limited Benefits Plans**

As you know, section 2718 of PHSA, as added by PPACA, directs that the standards for implementing the MLR requirements must “take into account the special circumstances of smaller plans, different types of plans, and newer plans.” As a result, both NAIC and HHS need to consider how limited benefits plans are affected by the MLR requirements.

It appears that PPACA’s MLR requirements were intended to apply to comprehensive plans. PPACA essentially federalizes MLR requirements. Whereas 34 states currently impose some form of MLR requirement on comprehensive plans, they do so in different ways and with different consequences. PPACA turns the various existing state standards into a uniform federal standard for comprehensive plans.² PPACA did not, however, intend to impose MLR requirements on limited benefits plans that are not subject to the same MLR requirements in the states today.

ASH and other limited benefits plans operate very differently from comprehensive plans. The nature of ASH’s business creates a number of cost factors that substantially lower ASH’s MLR. These include the following:

- **Lower cost of covered services.** Services covered by ASH (e.g., office visits, adjunctive therapies) are typically a fraction of the costs associated with the spectrum of primary and specialist services covered by comprehensive medical plans, including hospitalization and surgery claims. The limited set of relatively low cost professional services associated with the type of care covered by limited benefits plans results in a substantial difference in the ratio of medical services to administrative services as compared to comprehensive plans.

- **Fixed administrative expenses.** State regulators and accreditation agencies require the same administrative capabilities for limited benefits plans as they require for comprehensive plans. These services include credentialing of providers, provider contracting and network administration, quality management systems, clinical review systems, member appeals systems, provider appeals systems, claims processing, member services, provider services, data management and other capabilities. The actual cost of providing these required administrative services are roughly the same for each provider type and without regard to the scope of services covered. This means that administrative costs to meet regulatory and

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² The recent Senate Commerce Committee report on MLR issues, as well as the Committee’s investigation which preceded the report, focused exclusively on MLR standards for comprehensive plans. See *Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers*, April 14, 2010.
accreditation standards absorb a much higher percentage of premium for limited benefits plans as compared to comprehensive plans.

- Higher regulatory fees. Limited benefits plans often have to pay the same fixed-dollar amount for regulatory fees as do comprehensive plans. Because such fees do not account for premium levels, the costs have a much sharper impact on low premiums plans than they do on comprehensive plans with a much higher premium base.

- Lower premiums. Premiums for each type of service (e.g., chiropractic, acupuncture or massage therapy) rider available under the limited benefit plans offered by ASH typically cost just dollars each month per member. These low premium rates are a small fraction of what comprehensive plans receive. ASH nevertheless performs substantially the same administrative functions and transactions that a comprehensive plan does. While the cost for these functions and transactions are often the same regardless of the scope of coverage provided, the low premium associated with limited benefit plans means that those administrative costs represent a substantially higher percentage of premium for limited benefit plans as compared to comprehensive plans.

The lower cost of covered services, ASH’s fixed administrative costs, and low premiums received by ASH combine to reduce significantly ASH’s MLR.

The different cost structure of ASH’s operations means that limited benefits plans such as ASH could never reach the MLR targets of PPACA. These differences have been well understood historically by states, which have exercised discretion in evaluating the MLR of limited benefit plans, and, as such, have allowed the reasonable variations in ASH’s MLR instead of forcing such unique plans to arbitrarily satisfy the MLR requirements designed for comprehensive plans. NAIC understands these differences as well, as NAIC has adopted separate model acts regarding MLR for non-comprehensive insurance such as long term care, Medicare supplement, and disability.

Regulatory Clarification Is Needed

Even if there is a consensus that PPACA’s MLR requirements should only apply to comprehensive plans, regulatory clarification is needed. PPACA incorporated existing definitions from PHSA. PPACA applies MLR to “Health Insurance Issuers,” which are broadly defined by PHSA to include all licensed insurance companies. PHSA recognizes that not all insurers are the same, so identifies certain benefits—called “excepted benefits”—that are exempt from certain PHSA requirements. PPACA did not directly address whether the PHSA definitions are adequate for proper application of the MLR requirements. PPACA, however, did direct that regulations consider the effect of MLR on different plans.

While PHSA allows HHS by regulation to define “excepted benefits,” not all limited benefits plans currently fall within the current regulations at 45 C.F.R. § 146.145.3 Without further regulatory clarification, limited benefits plans that are outside the current scope of “excepted benefits” could be subject to MLR requirements that are impossible to meet. As a result, the current

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3 The April 20, 2010 letter from the American Academy of Actuaries to Lou Felice and Steven Ostlund also raises this issue by pointing out that “there are other types of health insurance not reported in the Comprehensive (Hospital & Medical) column [of the NAIC Health Annual Statement] that do not appear to fall under the definition of HIPAA ‘excepted benefits.’ . . . Do any or all of these types of policies fall under the scope of §2718? . . . Achieving clarity at an early stage as to which types of health products are included and excluded from the scope of the §2718 requirements would be beneficial to all interested parties, and in particular might help the NAIC formulate appropriate recommendations around §2718 reporting.”
MLR requirements could force limited benefits plans such as ASH to rebate a substantial amount of revenue to members, thereby rendering the business unsustainable. ASH could be forced to exit the specialty managed care market for complementary health care services.

To avoid this result, NAIC should urge HHS to make clear that the MLR requirements do not apply to non-comprehensive limited benefits plans.

If we can provide any further information, please do not hesitate to contact me.

Sincerely,

George DeVries
Chairman and CEO
April 30, 2010

Mr. Lou Felice
Chair, NAIC Health Care Reform Solvency Impact (E) Subgroup

VIA EMAIL

Dear Mr. Felice,

As the subgroup determines what expenses should be included in the definition of activities that improve health care quality in the calculation of the medical loss ratio under the Patient Protection and Affordable Care Act, Assurant Health submits the following for your consideration.

"Activities that improve health care quality" should be defined to include activities that: 1) relate directly to an individual patient's care; 2) provide tools to educate and inform patients about their current or future care; 3) prevent unnecessary and inappropriate care; and 4) ensure a minimum level of health care quality. All of these activities improve the quality of health care and/or enhance access to quality care.

Costs Related to Case Management and Patient Care

Costs related to the involvement in the care of customers bear a clear relationship to improving health care quality. For example, board certified physicians and licensed nurses that are available to our customers. These medical professionals interact with our customers in a variety of ways. To ensure that appropriate care is being delivered, medical staff may evaluate care to ensure it is medically necessary and appropriate. At times, independent review is utilized to determine medical necessity. In addition, we have a dedicated staff of nurses who perform case management duties which help customers manage their chronic and serious illnesses.

These professionals also help patients become more informed about their care and/or condition and understand the health care process, including the ongoing management of chronic conditions. This information allows customers to make better health care choices and avoid

unnecessary or inappropriate treatment. It also allows individuals to choose the right level of care for their condition and maintain compliance with the appropriate course of treatment. Moreover, the information and services provided by our medical team spurs discussion between providers and patients, resulting in a more open dialogue about the most effective treatment options. This involvement in patient care and the costs related to this involvement directly improve health care quality.

Costs for Educational and Informational Tools Related to Patient Care

Costs related to certain tools also improve the quality of health care. Tools that provide customers with information on how to best access care are important and effective components of an overall health care strategy. These tools might allow an insured to call and get information on qualified physicians in their area, as well as the costs associated with each one. This information is valuable in helping individuals find and choose quality health care. Such tools may also aid in making determinations about accessing affordable care and educate our customers, allowing for better choices regarding their health care.

Another important tool is the development of the PHR (Personal Health Record). The PHR is a single collection of an individual’s health record. This will allow for more prompt and effective treatment. It also allows an insured to be more knowledgeable about his/her own health history, which will produce better health care choices. In addition, a single, complete health record makes it easier and more efficient for providers to evaluate patients, also resulting in better care.

These same quality information tools are linked to cost information. Studies have shown that cost is linked to quality. These tools further the goals of price transparency which will aid in keeping prices down, thereby giving access to more citizens. It will also allow individuals to evaluate their providers to determine the best value for their money. Patients will be able to access and evaluate cost and quality information as they make their healthcare decisions. This is a necessary component to both increase the quality of care through consumer behavior as well as bend the cost curve for that care. As quality and price become more transparent, they will be factored into patients’ decisions on the selection of providers. This will result in lower quality providers being driven out of business, thereby increasing the overall quality of care in the health care system.
Costs Related to Prevention of Unnecessary or Inappropriate Health Care

Similarly, costs related to post-treatment review of billings improve health care quality. For example, provider fraud investigations are vital to ensuring that care is not being provided by unqualified providers and that treatment is accepted in the medical community and is appropriate. These investigations decrease the number of unnecessary tests/procedures and the inherent health care risks that are related to these unnecessary services. In addition, this information is communicated to the affected individuals and thereby educates him/her about any unnecessary care. This results in a decrease in inappropriate care and more informed consumers that are better able to make quality health care decisions.

Insurers also evaluate billings for compliance with generally accepted coding practices. Reviewing for unnecessary, duplicative, or cumulative billings increases the efficiency and ensures proper care in the future. One example of this kind of evaluation is the conversion to ICD-10, which classifies diseases used for clinical and epidemiological storage and retrieval of diagnostic information, health services payment, standardized health records, and public health assessment. The Department of Health and Human Services has already recognized that ICD-10 “will move the nation toward a more efficient, quality-focused health care system by helping accelerate the widespread adoption of health information technology,” January 15, 2009 DHHS Press Release (former DHHS Secretary Mike Leavitt).

Costs Related to Ensuring a Minimum Level of Health Care Quality

Many insurance carriers offer plans with network providers. These networks support the credentialing process and minimum credentialing requirements, which confirm providers’ board and DEA certifications, and state licenses, and ensure sufficient education and training. In addition, searches are conducted for any negative actions against providers, including malpractice data queries, CAQH databases, fraud, lawsuits, and any negative actions by a health plan, hospital, Medicaid, Medicare, State Board, or other professional organization. Moreover, network providers are also monitored periodically to ensure they continue to meet credentialing requirements.

Networks also ensure members have access to quality providers who agree to a fair and reasonable rate for services. Networks monitor the adequacy and accessibility of their network physicians: the number of physicians available compared with the population in a geographic area (ensuring a member has adequate selection amongst providers and all specialties
represented); the distance a member may need to travel to access available providers (ensuring accessibility according to the standard of their community); and the accessibility of such providers (wait times to get an appointment, wait times in the office). Furthermore, Network representatives act as a liaison for resolving quality issues encountered with network providers. In addition, Networks set policies and procedures which they require their providers to abide by to ensure continuity of care and coordination of care. All of these activities ensure that patients seeking care from a network provider will know their provider meets minimum standards of professionalism and quality of care. Not only do these activities help our customers avoid low quality providers, but they serve as a constant check on provider conduct and thereby improve the overall quality of health care.

Thank you for your attention and consideration to this important area of regulation

Sincerely,

Steven Dziedzic
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April 30, 2010

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

Re: Medical Loss Ratios – Section 2718 of the Public Health Service Act (PHSA)

Dear Mr. Felice:

On behalf of the more than 200 members of DMAA: The Care Continuum Alliance, I offer the following comments to National Association of Insurance Commissioners (NAIC) regulators and representatives as you consider classification of health plan expenses related to the calculation of Medical Loss Ratio (MLR).

DMAA: The Care Continuum Alliance represents organizations providing services along the continuum of care to more than 160 million Americans through wellness, chronic care management and complex case management. DMAA members include wellness, disease management and population health management organizations; health plans; labor unions; employer organizations; pharmaceutical manufacturers; pharmacy benefit managers; health information technology innovators and device manufacturers; physician groups; hospitals and hospital systems; academicians; and others. These diverse organizations share DMAA’s vision of aligning all stakeholders toward improving the health of populations. Our members seek to improve health care quality and contain health care costs by providing targeted interventions and services to individuals who are well, at-risk or managing one or more chronic conditions.

Section 2718(c) of the Public Health Service Act directs the NAIC to establish uniform definitions for activities that health insurance issuers offering individual and group coverage must report under Section 2718(a), including clinical services, activities that improve health care quality and all other non-claims costs and the nature of such costs.

Existing NAIC guidance on this issue — Statement of Statutory Accounting Principle (SSAP) 85, issued in 2002 — identifies case management and disease management programs as “cost containment expenses.” NAIC defines “cost containment expenses” as “expenses that actually serve to reduce the number of health services provided or the cost of such services.” Additional NAIC guidance directs “cost containment expenses” to be allocated as “administrative expenses” when calculating a health plan’s MLR.
DMAA: The Care Continuum Alliance has previously communicated to NAIC representatives its belief that SSAP 85 does not appropriately account for the significant positive impact on quality and health outcomes that disease and case management programs provide. DMAA has previously posited that these activities should more appropriately be classified as costs related to clinical care. In a recent paper developed on minimum loss ratios, the American Academy of Actuaries describes “case management, disease management, 24-hour nurse hotlines, wellness programs” as more “akin to benefits than administrative expenses” and appropriately factored into the value of benefits for the calculation of medical loss ratio (American Academy of Actuaries, February 2010).

Specifically, wellness, disease and case management services improve and support the health of populations and are important components of population health management programs. These services support a physician-guided health care delivery system and engage and support patients to mitigate illness and improve long-term health. Wellness, disease and case management services are built on a foundation of evidence-based clinical care and are measured by clinical impact on health status. These programs and services educate patients and promote self-management skills; provide coaching and nurse support; ensure safe transitions in care; improve medication adherence and management; coordinate care between providers and care settings; and enhance quality through evidence-based decision support, data analytics, disease registries and other technologies. These services are primarily provided by licensed, clinical health care practitioners in and across numerous health care delivery settings and offer benefits far beyond cost containment and claims adjustment activities.

DMAA: The Care Continuum Alliance urges the NAIC to support the classification of these services as either “medical expenses” or “quality improvement expenses” for the purpose of calculating a health plan’s MLR under the requirements of The Patient Protection and Affordable Care Act (PPACA), PL 111-148.

DMAA: The Care Continuum Alliance looks forward to serving as a resource for NAIC regulators and representatives as you consider these important issues.

Sincerely,

Tracey Moorhead
President and CEO

cc: Richard Diamond, Chair, Actuarial MLR Subgroup
    Todd Sells, NAIC Staff
    John Englehart, NAIC Staff
    Brian Webb, NAIC Staff
April 30, 2010

Mr. Steve Ostlund  
Chair, Accident and Health Working Group  

Mr. Lou Felice  
Chair, Health Reform Solvency Subgroup  

Re: Medical Loss Ratio under 2718 of the Public Health Services Act  

Dear Mr. Ostlund and Mr. Felice:  

We are writing to you as the group of NAIC consumer representatives who have been working on the issues that have arisen concerning the medical loss ratio provisions of the Patient Protection and Affordable Care Act. We write to address an issue raised by Shari Westerfield of the Blue Cross and Blue Shield Association in her letter to you of April 27, 2010—the role of loss adjustment expenses in calculating medical loss ratios for purposes of determining rebates due to consumers under section 2718 of the Public Health Services Act. We realize that this provision is not a model of clear legislative drafting, but believe that the construction that Ms. Westerfield puts on this provision is in error.  

The purpose of section 2718 of the Public Health Service Act, added by section 1001 of the PPACA, is, as announced in its title “bringing down the cost of health care coverage.” The strategy that the law adopts for accomplishing this is to require health insurers to spend at least a minimum percentage of premiums on health care services or on activities that improve health care quality for enrollees.  

Section 2718 consists of five subsections and requires insurers to provide information accounting for their costs in a number of expenditure categories using a number of different ratios. First, section 2718(a) requires insurers to submit to HHS “a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. This ratio is:  

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\frac{\text{Incurred loss + loss adjustment expenses (or change in contract reserves)}}{\text{earned premiums}}.  
\]

This ratio is not mentioned again in the statute.  

Second, insurers are also required to report three other ratios, namely:  

The percentage of total premium revenue, after accounting for collections of risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—  
(1) on reimbursement for clinical services provided to enrollees under such coverage;  
(2) for activities that improve health care quality; and  
(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.
These ratios are:

- Clinical services reimbursement/ premium revenue + or – risk pooling
- Health care quality activity payments/ premium revenue + or – risk pooling
- Other non-claims costs – taxes and regulatory fees / premium revenue + or – risk pooling

These three ratios also do not play a further role in the statute, although components of them do.

Section 2718(b), the operative section requiring rebates, turns on yet a fifth ratio, different from any of those reported under subsection (a). This ratio is “the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance” for a plan year...”, represented as:

\[
\text{Clinical services reimbursement + quality activity costs / premium revenues – taxes and regulatory fees + or – risk pooling}
\]

Under 2718(b)(1)(B), this becomes the key formula in the provision. If this ratio falls below 80 percent in the individual or small group market or 85 percent in the large group market (or such higher rate as a state imposes or unless HHS determines that the 80 percent ratio will destabilize the market), the insurer must pay a rebate to its enrollees.

The operative ratio of 2718(b) does not include loss adjustment expenses in its numerator. Although loss adjustment expenses are included in the numerator of the first ratio described in 2718(a), this first ratio (which also does not account for taxes, regulatory fees, or risk pooling) is not the ratio that determines the rebate. Loss adjustment expenses are defined by the Brokers and Reinsurance Markets Association to include:

- Loss Adjustment Expense" means all costs and expenses allocable to a specific claim that are incurred by the Company in the investigation, appraisal, adjustment, settlement, litigation, defense or appeal of a specific claim, including court costs and costs of supersedeas and appeal bonds, and including post-judgment interest.

They also may include under some BMRA definitions:

- b) post-judgment interest; c) legal expenses and costs incurred in connection with coverage questions and legal actions connected thereto; and d) a pro rata share of salaries and expenses of Company field employees, and expenses of other Company employees who have been temporarily diverted from their normal and customary duties and assigned to the field adjustment of losses covered by this Contract.

These are core administrative functions of insurance companies. Loss adjustment activities do not provide health care services or improve the quality of care received by enrollees. Indeed, a major function of loss adjustment activities is to deny services to
enrollees and to contest their claims to services. It is inconceivable that Congress intended these costs to figure into the numerator of the formula ultimately used to calculate rebates, even though they do appear in one of the other formulas reported by insurers.

We trust that the NAIC and HHS will focus on the intent of Congress and the clear wording of 2718(b), and reject Ms. Westerfield’s interpretation of the statute. Please contact Timothy Jost at 540 421 1529 or jostt@wlu.edu if we can be of any further assistance in this matter.

Sincerely,

Timothy Stoltzfus Jost
Wendell Potter
Kim Calder
Bonnie Burns
Elizabeth Abbott
Kevin Lucia
Medical Loss Ratios

The Patient Protection and Affordable Care Act (PPACA) requires health insurance issuers offering individual or group coverage to submit annual reports to the Secretary of Health and Human Services that show the percentages of premiums that the coverage spends on reimbursement for clinical services and activities that improve health care quality, and to provide rebates to enrollees if this spending does not meet minimum standards for a given plan year. The consumer representatives to the NAIC applaud lawmakers both for their understanding of the importance of setting minimum standards for medical loss ratios and also for the strong emphasis in PPACA on improving quality of care.

PPACA directs the NAIC to establish uniform definitions of activities being reported to the Secretary and standardized methodologies for calculating measures of these activities no later than December 31, 2010. The NAIC consumer representatives believe it is critically important that the regulations prohibit insurers from classifying or reclassifying certain administrative expenses as medical expenses, and from taking other actions unrelated to quality improvement that would automatically increase their medical loss ratios. We believe that allowing insurers to boost their medical loss ratios (MLRs) in such artificial ways would violate Congressional intent.

We also believe that because the development of definitions and measurements of insurers’ MLR requirements is of such critical importance to consumers, the process of developing the definitions and standards must be transparent and include consumer group participation and input.

Background and Discussion

Section 2718(C) provides that, beginning not later than January 1, 2011, health insurance issuers offering group or individual health insurance coverage must with respect to each plan year provide an annual rebate to each enrollee under such coverage if the ratio: (1) the amount of premium revenue the issuer spends on reimbursement for clinical services provided to enrollees and activities that improve health care quality to (2) the total amount of premium revenue for the plan year (excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of PPACA) is less than the following percentages, referred to as “the applicable minimum standards”:

- 85 percent for coverage offered in the large group market (or a higher
percentage that a given state may have determined by regulation); or

- 80 percent for coverage offered in the small group market or in the individual market (or a higher percentage that a given state may have determined by regulation), except that the Secretary may adjust this percentage for a state if the Secretary determines that the application of the 80 percent minimum standard may destabilize the individual market in that state.)

Section 2718(b)(1)(B)(ii) requires that beginning on January 1, 2014, the determination of whether the percentage that the coverage spent on clinical services and quality improvement exceeds the applicable minimum standard (under Section 2718(b)(1)(A)) for the year involved shall be based on the average of the premiums expended on these costs and total premium revenue for each of the previous three years for the plan.

PPACA also directs the NAIC to develop uniform definitions and methodologies for calculating these percentages (subject to certification by the Secretary).

In anticipation of the law's requirement that health insurers meet minimum MLR standards, at least one insurer began taking actions that would make it much easier for the company to comply with the law simply by reclassifying certain administrative expenses as medical expenses. As reported widely by the media, WellPoint executives told investors in March they already had begun reclassifying several categories of expenses that would result in a substantial increase in its 2010 MLR. The company said its reclassifications involved expenses related to its “nurse hotline” and health and wellness activities, including disease management and medical management programs, and expenses pertaining to “clinical health policy.” By reclassifying these expenses, WellPoint projected that its 2010 medical loss ratio would increase by 170 basis points, or 1.7%. The Office of Oversight and Investigations for the U.S. Senate Commerce Committee noted in an April 14, 2010, report that because WellPoint expects to collect more than $30 billion in premiums from its commercial health customers in 2010, “this ‘accounting reclassification’ means that the company has converted more than a half a billion dollars of this year's administrative expenses into medical expenses.”

Other insurers are expected to follow WellPoint's lead. Insurers have proposed such reclassifications in the past when states have considered adopting minimum MLR requirements. When California was considering minimum MLRs in 2007, one insurer proposed that any services to improve health outcomes or reduce health care costs should be included in the medical portion of the ratio, such as: disease management programs; wellness programs, care management programs, nurse hotlines, quality assurance oversight activities, health information technology expenses; transparency initiatives; and provider credentialing.

It is important to note that until lawmakers began focusing on MLRs, insurers thought that expenses related to those costs were categorized appropriately as administrative costs—not medical costs. Significantly, when the California legislature did not enact a minimum MLR provision, the company took no action to reclassify the expenses.

While NAIC accounting rules pertaining to MLRs define “medical loss” as the value of medical claims an insurer actually paid (“incurred claims”), plus the amount of money the insurer sets aside to pay future claims (“contract reserves”), the Patient Protection and Affordable Care Act will potentially allow insurers to classify a broader set of expenditures as medical. But, as the U.S. Senate Commerce Committee report noted,
“Boosting medical loss ratios through creative accounting will not fulfill the new law’s goal of helping consumers realize the full value of their health insurance payments.”

Further, because the new law will in 2014 prohibit insurers from denying coverage or refusing to pay claims for anyone with preexisting conditions, insurers after that date should no longer need to spend as much as they do today on underwriting activities. Similarly, since Congress has passed a healthcare reform package, funds spent on lobbying should be greatly reduced. When underwriting and lobbying-related expenses are reduced, insurers’ MLRs should rise as a direct consequence, which will make it considerably easier for them to comply with the minimum ratios set forth in PPACA. MLRs will rise even further if the amount of money paid in commissions to brokers declines once the exchanges in operation.

**Recommendations**

As HHS and the NAIC approach the task of deciding how to classify health insurance costs, they must not allow whole categories of administrative work to be re-defined as medical costs, especially if the category or department has only a partial medical care role. While the inclusion of evidence-based quality improvement initiatives in an insurer’s MLR would appear to be what lawmakers intended by including “activities that improve health care quality” in the section of the new law pertaining to MLRs, the new regulations should not allow insurers to classify expenses for which there is little or no evidence that the related activities “improve quality.” For example, most consumers would not consider “utilization review” nurses and other administrators whose job it is to review and often deny physician-recommended treatments to be providing medical care or, in many if not most cases, “improving quality” of their health. Likewise, quality assurance programs and provider credentialing activities are administrative functions that insurers have not considered direct medical expenses in the past and should not be allowed to be reclassified as such now.

Information technology spending is another area too broad to allow wholesale reclassifications. Some investments in IT have contributed to greater adherence to clinical guidelines and, as a result, might have improved quality of care. Further, plans can and should help physician practices make the investments they need to meet the “meaningful use” requirements recently promulgated by the Centers for Medicare and Medicaid Services. Information technology spending can lead to more streamlined operations, fewer mistakes and duplications and, consequently, better patient outcomes and lower medical costs. But many other areas of IT spending have nothing to do with improving quality. Insurers have invested in information technology to enhance underwriting capabilities, reduce expenses pertaining to paying claims and even to identify unprofitable accounts. It is also important to note that insurers have not in the past included IT expenditures as direct medical costs. Insurers have invested in IT to give them competitive advantages and for research and development purposes. Regulations pertaining to IT spending must include a methodology to ascertain and allocate an appropriate portion of technology infrastructure costs directly tied to quality initiatives—with rigorous oversight.

In addition, “medical management” is such an all-encompassing term that it can include purely administrative functions as well as the salaries of employees whose work does
not in any way improve quality. Many “medical management” expenses, including expenses related to “nurse hotlines” and proprietary disease and care management programs, are related more to cost control or expense management than to improving quality. While nurse hotlines can be a useful tool for consumers, there is the potential for them to be used by insurers to reduce utilization without regard to medical necessity.

Health plans frequently cite their disease management programs as evidence of a focus on improving the health of people with chronic conditions. One insurer said recently it has 34 different disease management programs in place. Yet as of 2010, the National Committee for Quality Assurance (NCQA) has accreditation programs for only five disease management programs: asthma, diabetes, chronic obstructive pulmonary disease, heart failure and ischemic vascular disease. (The NCQA has separate preventive health measures for tobacco use, influenza vaccination and pneumococcal vaccination). Many disease management programs operated by health plans lack verifiable evidence demonstrating that they improve patient outcomes.

Health plans should not be discouraged from offering evidence-based disease and care management programs, but no program should be included for which there is insufficient empirical evidence that it improves the health of enrollees. In order to advance and support the overall quality agenda within PPACA, we believe the NAIC could consider as allowable quality improvement expenses the following: expenses related to implementing and maintaining the QI program required by Medicare, Medicaid, the Child Health Insurance Program and other government programs; expenses relating to establishing and updating the data collection and reporting required to comply with the Secretary of HHS’s national strategy to improve the delivery of health care services, patient health outcomes and population health; and expenses related to government QI demonstration projects. Plans should be required to be much more transparent in this area and should be required to provide cost and outcome results of such programs. Before regulators consider allowing these programs to be classified as medical expenses, they should ask the following questions: "Does the program result in reduced claims for the insurer? If yes, does the program also have a documented and demonstrable impact on improved quality? If no, then it should not be construed as a medical expense. If yes, would the insurer offer the program if it did not have an impact on reduced claims? If no, then it should not be construed as a medical expense."

Consumer-focused services that health plans should be allowed to classify as medical care are professional interpretation and translation services in health care settings for enrollees who are limited English proficient (LEP). For these plan participants, language access resources are an integral part of the clinical encounter. Moreover, health plans should not be discouraged from providing these services to LEP enrollees when communicating with them about covered benefits and other plan information. Unless it is for marketing purposes, plans should also be permitted to consider as “quality improvement” interpretation and translation services used when directly communicating with LEP enrollees.

Other considerations:

- Insurers should be prohibited from grouping their plans together to mask the low MLRs of some of their plans. The new law may incentivize insurers to combine
into the largest groups possible to have their most profitable plans offset by their least profitable ones.

- If insurers operate under several legal entities in a state, they should not be allowed to combine results. Insurers separated entities for a reason: to limit liabilities. They should not now be able to combine their entities’ MLRs.

- Medicare Part D and specialized and supplemental products, such as vision only, dental only and Medicare supplement plans should be exempted from inclusion in the loss ratio requirement, so that the requirement is limited to health insurance.

- Insurers should not have the flexibility to pool their experience across different product lines/markets at their discretion. Additionally, an insurer should not have the flexibility to average its premium equivalents under administrative services only (ASO) contracts. Insurers should also not be allowed to pool their experience across different states.

- The MLR should be based simply on paid claims. Insured claims, as noted earlier, are the sum of claims paid and changes in reserves (not paid claims plus all reserves). Since the review is historical, use of actual claims paid is reasonable and avoids the possibility of insurers gaming the system by manipulating reserves.

- Some insurers would like to have a special consideration or accommodation for their low cost products, e.g., limited-benefit and high-deductible plans and possibly even so-called “mini-med” plans, because, in their view, a high medical loss ratio requirement would discourage insurers from offering such products. Products with lower premiums (made possible by reducing benefits and/or requiring enrollees to pay more out of their own pockets than they would under higher premium products) have a higher percentage of revenue attributable to administrative costs. Because these products shift more of the cost of care from insurers and employers to consumers, they also typically have high profit margins. Insurers should not be given any special consideration in computing the MLRs for such products. Many of these products contribute to the growing number of people who are underinsured.

- The cost of settling claims—considered a loss adjustment expense—must not be included in the MLR numerator used for determining rebates. Expenses related to settling claims are not payments for health services. Including them in the MLR numerator would provide a perverse incentive for insurers to spend more money on denying claims. Although section 2718(a) requires insurers to report their loss adjustment expenses together with incurred claims, it separately requires insurers to report expenditures for reimbursements for clinical services and for activities that improve health care quality. Under 2718(b), only the latter two categories of expenses are considered in determining rebates. “Reimbursement for clinical services” clearly does not include loss adjustment expenses.

- Regulators must insist that health plans be transparent in what they include in the MLR numerator. If the NAIC and HHS allow any expenses related to “quality
improvement” activities to be reclassified as medical expenses, consumers must be able to see exactly how much plans are paying on claims. Therefore, **plans must be required to report on the amount they spend on the payment of claims, separate from the total amount they report for the numerator in the MLR ratio.**

- Finally, it should be noted that insurers gain an important advantage under PPACA, which will boost some MLRs. Small groups currently are defined as groups with 50 or fewer employees. The new law raises that definition to 100 employees. Since small groups have more generous MLR minimums, this definitional change will move groups of 51-100 from large to small groups with a 5% greater MLR allowance, providing additional insurer margins.

**An additional—and important—recommendation**

If carriers are permitted to shift or reclassify any expenses, they should be required to restate their MLRs over the previous five years using the new standards and definitions so that the public—as well as lawmakers, regulators and shareholders—can see the effects of the new definitions on the reporting of MLRs. There are precedents for requiring such restatements by carriers. It is not at all uncommon for the SEC to require publicly traded companies, including insurers, to restate earnings retrospectively following the discovery or disclosure of information considered material to earnings. Similarly, carriers have restated membership totals after discovering that their previous methods of calculating membership totals were flawed. If the HHS, NAIC and SEC are truly dedicated to transparency, they will insist that carriers restate their MLRs retrospectively for a specified period of time.
May 4, 2010

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

Re: Medical Loss Ratios – Section 2718 of the Public Health Service Act (PHSA)

Dear Mr. Felice:

Health Dialog appreciates the opportunity to provide comments to NAIC regulators and representatives on Section 2718 of the Public Health Service Act (PHSA) added by the Patient Protection and Affordability Care Act (PPACA). Our comments specifically focus on the classification of health plan expenses related to the calculation of medical loss ratios (MLRs).

Health Dialog Services Corporation is a leading provider of healthcare decision programs to over 20 million people around the world. These programs include health coaching for medical decisions, chronic conditions, and wellness; nurse line services; analytic solutions and consulting services. Health Dialog works with health plans, payers, and providers to help them better understand their populations and improve the quality, efficacy and appropriateness of the healthcare services they receive. Our health coaches encourage and support individuals to participate in their own healthcare decisions, and work with them to develop more effective relationships with their health care providers. We employ over 550 healthcare professionals including licensed nurses, respiratory therapists, pharmacists, and registered dieticians, with on average, 10 to 15 years of experience, who help our members manage their overall health and wellbeing. We also have health coaches who are certified diabetic educators, tobacco cessation specialists, health educators, and behavior change specialists.

Health Dialog’s services consist of four important components of population health management. Those components are identification, population analysis, coaching, and healthcare decision support. We use predictive modeling to identify those individuals who might benefit most from our programs and then reach out directly to those identified individuals via various communication channels to offer our personal health coaching services. Eligible individual members can also contact our health coach telephone service for support and information. Our health care coaches supplement their telephone conversations by providing additional evidence-based and unbiased information on treatment options, screening, and chronic diseases. Health Dialog’s Shared Decision Making® program is available across a wide range of medical conditions and is delivered in multiple formats including print, video, and interactive web resources so patients can better understand their conditions. We also have the capability to analyze a health plan or employer’s overall population to determine variations in healthcare delivery of
services. This population analysis enables us to work with our clients in developing and implementing strategies to improve the quality, effectiveness and efficiency of healthcare at the individual and population level. We believe the types of services Health Dialog provides to our health plan clients are at the core of improving the overall quality of the health care experience and health of our members. The full range of services improves the quality of care provided to our members by ensuring that the right care is delivered at the right time which also reduces costs for the health plans, payers, and providers we serve. Analytics, decision support and disease or care management services improve health management and care delivery at an individual and community level. One consequence of these improvements is cost containment for health plans. We agree with the Academy of Actuaries assertion that “case management, disease management, 24-hour nurse hotlines, wellness programs ... and preventive programs are more akin to benefits than administrative expenses” and should be factored into the value of benefits for purposes of the calculation for medical loss ratio (American Academy of Actuaries, February 2010). Section 2718 (c) of the PHSA directs the National Association of Insurance Commissioners (NAIC) to establish uniform definitions relating to activities that health insurance issuers offering individual and group coverage must report under Section (a) including clinical services, activities that improve health care quality, and all other non-claims costs and the nature of such costs.

Health Dialog urges the NAIC to support the classification of these services as “medical expenses” or, in the alternative, “quality improvement expenses” for purposes of calculating a health plan’s medical loss ratio (MLR) under the requirements of Section 2718 (c) of the PHSA.

We appreciate the opportunity to provide comments on this important issue and look forward to providing any further information as requested by NAIC. I can be reached directly at 617/406-5258.

Sincerely,

Mark Hampton
Chief Financial Officer
Medical Loss Ratio (MLR)

The final regulation should further key goals of health care reform:

I. Quality Improvement and Affordability

1) Accurate Definitions of Quality and Claims: The definition of activities that improve health care quality and clinical services must allow for the inclusion of the wide array of insurer functions that provide value for consumers. In addition, the claims definition should provide a level playing field among different types of insurers (e.g., HMO vs. PPO) by adopting the NAIC definitions of claims and related expenses.

2) Scope of Benefits: MLR rules should not apply to HIPAA excepted benefits.

3) Exclusion of State and Federal Costs: MLR should be calculated after excluding state and federal assessments, taxes and other costs from revenue.

II. Enhancement of Competition

4) Appropriate Aggregation: The large group MLR should be at the holding company level for the largest geographic area covered.

5) Credibility Allowances: For the individual and small group markets, adopt a modified version of the credibility table that is included in the NAIC Annual Medicare Supplement Refund Calculation form.

6) Market Monitoring: Assure that federal and state regulators have clear direction to lower MLRs if solvency or competition deteriorates.

7) Rolling Averages: Beginning in 2011, insurers should be allowed to calculate MLRs based on three year rolling averages.

8) Transitional Rules: A portion of broker commissions should initially be excluded from premium revenue. The percentage excluded would be reduced every year until 2014, when broker commissions would no longer be excluded from premium revenue.

III. Administrative Efficiency

9) Calendar Years: MLRs should be based on a calendar year basis.

10) Rebates: Rebates should take the form of premium credits to current customers. De minimus rebates should be provided to state high risk pools or risk adjustment mechanisms.


Legislative Background

The Patient Protection and Affordable Care Act (PPACA) includes the following provisions impacting MLR:

- Insurers are required to submit an MLR report to HHS Secretary
- MLR requirements are 85% for the large group, 80% for the small group and individual markets
- Secretary can adjust the 80% MLR in a state if the Secretary determines that such requirements may destabilize the individual market
- Insurers must provide an annual rebate to enrollees if minimums are not met
- The NAIC will establish uniform definitions of activities and standardized methodologies for calculation of the MLR, subject to the Secretary’s certification
I. **Quality Improvement and Affordability**

**Recommendation #1: Accurate Quality Definition**

The definitions of activities that improve health care quality and clinical services should include:

**Part A: Activities to Improve Health Care Quality**

As the purchaser of health care services for more than 170 million Americans, health insurers play a pivotal role in implementing mechanisms to improve care quality. This role has long been recognized by government agencies such as the Agency for Healthcare Research and Quality (AHRQ), independent accreditation bodies such as the National Center for Quality Assurance (NCQA) and the Utilization Review Accreditation Committee (URAC), and an array of public interest initiatives to advance health quality including the National Association for Healthcare Quality, the American Health Quality Association, the Quality Assurance Project, the NYS Health Accountability Association (and many analogous programs of other states), the National Initiative on Children’s Health Care Quality, the Institute for Healthcare Improvement, the National Quality Forum, the Leapfrog Group, Bridges to Excellence and the Center for Payment Reform. Most health plans are required to maintain quality assurance and utilization review programs by state law. Similar requirements are reflected in the Federal HMO Act. Most plans also maintain accreditation by either NCQA or URAC and actively participate in quality improvement initiatives sponsored or supported by the other agencies noted above.

The definition of quality improvement initiatives should be based on the Institute of Medicine’s (IOM’s) six “Aims for Improvement” -- activities designed to make care more safe, effective, patient-centered, timely, efficient, or equitable and should include:

- **Quality Assurance:** Health plans routinely gather, analyze and report health care quality information, including HEDIS and other standardized provider and care quality measures, as part of their core operations. Many of these activities are required by NCQA for plan accreditation, URAC, HEDIS and state departments of health.
  - Quality reporting is recognized as a quality function in PPACA in sec. 2717 (Ensuring Quality of Care).
  - The collection and analysis of this data allows health plans to assess the quality of care provided to their members and to develop new programs, procedures and activities to improve that quality. HEDIS reporting by health plans is one of the fundamental sources of care quality measurement in the United States.
  - Specific activities include: quality assurance activities; mandates by law/regulation; provider quality measurement, review, and reporting; credentialing; and care effectiveness assessments. NCQA specifically includes credentialing as part of its requirements.

- **Utilization Review:** Ensures that patients are provided with evidence-based medical treatments which are best suited to their specific needs, conditions and situations. This program protects consumers from undergoing unnecessary procedures that could threaten their health; unnecessary surgeries could also be reduced. U.S. estimates of the combined effect of errors and adverse effects that occur because of iatrogenic damage not associated with recognizable error, include 12,000 deaths per year from unnecessary surgery. Other rationales for inclusion of utilization review as part of the quality definition include:
Utilization review that uses medically-approved standards of care can help to identify and reduce unnecessary services—which cost the U.S. about $700 billion according to OMB director Peter Orszag. Some experts, such as Elliot Fisher and John Wennberg, estimate that up to 30% of health care is unnecessary.

Utilization review programs (and specifically prior authorization and pre-certification processes) are based on clinical guidelines, EBM, peer review, and are credentialed programs.

Implementing activities to prevent hospital admissions, as well as activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, EBM and health information technology are recognized as quality functions in Sec. 2717 (Ensuring the Quality of Care) of PPACA.

The Medical Management Guide issued by the Office of the Assistant Secretary of Defense defines utilization management as a “…key process within Medical Management …for improving the quality of health care…..

Hospital-based utilization review has been critical in patient safety—in which medical services and records are specifically reviewed for quality of care and appropriateness of place of service. It has improved quality by decreasing life-threatening errors.

Government contracts with insurers generally require performance of utilization review (e.g., FEHBP, TRICARE, state contracts). Washington State defines the process as “…comparing requests for medical services (“utilization”) to guidelines or criteria that are deemed appropriate for such services, and making a recommendation based on that comparison.

The Social Security Administration has stated when describing its history of Medicare and its requirement of utilization review, that “The health care professions had recognized for some time the need for mechanisms which would assure quality care to patients through sound utilization of institutional facilities and professional services.

Through a pre-certification process for bariatric surgery, an Aetna member discovered that he needed surgery for a very serious heart condition, and also participated in a physician-supervised nutrition and exercise program that eliminated the need for the bariatric surgery.

Some Florida Medicaid services are subject to utilization review by a Quality Improvement Organization (QIO) under contract with Florida’s AHCA. The purpose of the utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to Medicaid recipients. The following Medicaid services are subject to review by a QIO: inpatient hospital services, home health services, community mental health services, and home and community based waiver services for the developmentally disabled.

Utilization review that uses medically approved standards of care recommendations to identify unnecessary or inappropriate services could also help to reduce the preventable adverse events that the IOM identifies as a leading cause of death in the United States. The IOM says:

- When extrapolated to the over 33.6 million admissions to U.S. hospitals in 1997, the results of these two studies imply that at least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors.
- Deaths due to preventable adverse events exceed the deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).
• **Patient safety, care effectiveness and care optimization activities:** Includes protocol-based assessments of gaps in care, ineffective/inappropriate care, potential medical errors (e.g., drug interactions) and optimal treatment pathways based on individual needs.
  - Medication and care compliance activities and activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, EBM and HIT are recognized as quality functions in PPACA in sec. 2717 (Ensuring Quality of Care).
  - Adverse drug events result in more than 770,000 injuries or deaths each year.
  - IOM identifies preventable adverse events as a leading cause of death in the United States and also states that:
    - Based on 33.6 million admissions to U.S. hospitals in 1997, 44,000-98,000 Americans die in hospitals each year as a result of medical errors.

• **Disease and Care Management Programs:** Provides assistance in managing chronic disease and critical illness/injury, including disease management, care management and critical illness programs. Members in these evidence-based programs have superior medical outcomes and satisfaction.
  - Aetna Health Connections Disease Management (based on evidence-based medicine) helps people with chronic conditions obtain the treatment and preventive care they need. Aetna’s clinicians help members understand and follow their doctor’s treatment plan and better manage ongoing conditions. Specifically, it has resulted in:
    - A 2005 Aetna study on congestive heart failure members showed a 26% reduction in ER visits, 15% reduction in inpatient admissions and 25% reduction in medical and pharmacy costs.

• **Institutes of Excellence and Critical Case Support:** Customized care coordination for members requiring specialized care for critical illnesses or injuries, including identification of regional and national centers of excellence for specialized care and member assistance in accessing care through these centers.
  - Without logistical support, these members would have more difficulty utilizing these providers and would experience a lower quality of care.
  - Research shows that aligning with Leapfrog’s protocol for referrals to facilities that specialize in performing those specific services with frequency, demonstrated that a patient’s risk of dying could be reduced by 40%.

• **Wellness programs:** Includes health counseling, health assessment and screening, incentives for healthy behaviors, wellness programs (e.g., smoking cessation) and costs associated with arranging access to third party fitness and wellness programs. Wellness empowers members to make positive and permanent lifestyle changes to improve their health. Wellness and prevention programs, including web based intervention efforts, are recognized as quality functions in PPACA in both sec. 2717 (Ensuring Quality of Care) and sec. 1311(g)(1) (Rewarding Quality Through Market Based Incentives).

• **Health counseling and information services:** Provides members telephone access to doctors, nurses and counselors experienced in providing information on a variety of health topics. This allows members to obtain information to improve their health.
  - Several Aetna programs provide members with physician-specific indicators based on adverse events and overall efficiency, and hospital information about specific diagnoses and procedures and empower them to evaluate the overall value and cost of care before they access services.
“Periodic contact [of nurses] with people with [multiple chronic] conditions improves self management or recognition of symptoms early enough to prevent deterioration requiring hospitalization.”

- **Health information technology (HIT), including electronic health records (EHRs) and protocol-driven care review:** Health information tools allow clinical information to be shared in real time among patients and providers, reducing the risk of medical errors and unnecessary/ duplicative services. These record-sharing mechanisms include personal health records (PHRs), EHRs, and regional health information organizations (RHIOs). The following demonstrate some of the quality improvement that HIT brings:
  - HIT is recognized as an activity to improve patient safety and reduce medical errors by PPACA in sec. 2717 (Ensuring the Quality of Care), and in sec. 3013 (Health Care Quality Improvement: Quality Measure Development).
  - Aetna’s Care Engine technology provides a major enhancement to electronic medical records by continuously reviewing member health activities against more than 10,000 evidence-based care protocols to identify gaps in care, opportunities for care improvement and potential health risks associated with adverse care interactions. The Care Engine technology provides alerts to doctors and patients about opportunities for care improvement and even potentially life-threatening risks.
    - Care Engine use has demonstrated an 8.4% decrease in hospitalizations.
  - Research has demonstrated higher levels of average quality for hospitals with electronic health records and computerized physician order entry
  - VA’s investment in the Veterans Health Information Systems and Technology Architecture is associated with significant value through reductions unnecessary and redundant care, process efficiencies, and improvement in care quality. Conservative estimates quantify VA investments over four years as yielding $3.09 billion in cumulative benefits net of investment costs.

**ICD-10:** The adoption of the 10th version of the ICD code set will provide an additional level of detail regarding patient care in order to enhance the ability to maximize quality for patients and to further research that can improve aggregate patient outcomes, as well.
  - According to former Department of Health and Human Services Secretary, Mike Leavitt, “The greatly expanded ICD-10 code sets will fully support quality reporting, pay-for-performance, bio-surveillance, and other critical activities. The updated X12 transaction standards, Version 5010, provide the framework needed to support the ICD-10 codes.”
  - Consistent use of "E" codes (external causes of injury and poisoning), facilitated through the use of ICD-10 codes could improve the likelihood of the recognition of medical errors and “might improve the recognition of the magnitude of their effect,” according to a 2000 JAMA article.
  - New ICD-10 codes can facilitate better disease management through new obesity codes and other more granular diagnosis codes.

- **Fraud prevention:** Fraud units identify providers that are engaging in fraud through a number of ways – false credentials, provision of unnecessary services or failing to provide reported procedures. These efforts protect consumers from providers who have lied about their qualifications or about the level of care necessary or provided. Consumers are safer as a result and enjoy a higher level of quality care. The following are examples of how anti-fraud efforts protect patients and further quality:
Under a “rent-a-patient” scheme discovered by Blue Cross and Blue Shield plans, a group of California-based surgery centers and medical management companies paid people as young as 12 to have unnecessary medical procedures. The surgery centers would use prompt-payment laws to pressure insurers to reimburse them within 45 days, before the fraud could be detected.xx

A GAO report (1992) states “the vulnerability of the health care system to fraud and the financial damage that it can cause is illustrated by a California scheme that has resulted in the loss of millions of dollars…the [rolling] labs provided patients a battery of costly and often unnecessary tests, which were billed to the patients’ insurers.” Anytime individuals undergo unnecessary procedures, they may be put at risk.

- **External Review and Appeals:** Ensures patients access appropriate care in a timely fashion – assuring the best outcomes possible and avoiding unnecessary, dangerous procedures that could threaten health.
  - The Agency for Healthcare Research and Quality’s Health Care Utilization Project estimates that unnecessary services result in 37,136 deaths and a cost of 122 billion dollars.
  - External review systems ensure that services rendered align with medical based protocols.
  - An external review process is mandatory for NCQA and URAC accreditation

- **Population Health Quality Improvement:** Includes a range of activities, including programs aimed at reducing racial and ethnic inequality of care, addressing population health risks such as obesity and smoking, improving health risk detection and prevention among women, children and other segments of the population, and providing compassionate end-of-life care.
  - Population health is one of three components of the recently nominated CMS Administrator Donald Berwick and colleague’s “Triple Aim” vision for improving the healthcare system (along with improving the experience of care and reducing the per capita cost of care).
  - Speaking about efforts to improve health literacy: “Informed patients have better outcomes; they are more concordant with the people who provide health services; they seek care earlier because they recognize warning signs; they read and comprehend instructions; they understand what their doctors advise them to do and they are not afraid to ask questions when they do not understand.”xx

These programs are a consistent component of PPAC’s definition of quality:
  - Section Sec 1311(g)(1): “Rewarding quality through market based incentives” includes activities to reduce health and health care disparities, such as through the use of language services, community outreach and cultural competency training in the programs it considers quality improvement.
  - Section 3011: National Strategy to Improve Health Care Quality Priorities lists as priorities: “Reducing health disparities.”
  - Section 3013: Supports Quality Measure Development to assess health disparities across health populations and geographic areas.

- **Comparative Effectiveness, Pay for Performance and High Performance Networks:** Includes assessment of provider care effectiveness, the formation and support of provider networks based on care quality and efficiency, and payment methodologies designed to incent continuous quality improvement. The following are examples of the quality aspects of these programs:
• Aetna has established a high performance network program called the Aexcel Network, in which specialists who have met certain clinical quality and efficiency standards are recognized.

• Medicare implements pay for performance to improve quality.

• The American Recovery and Reinvestment Act (ARRA) contains $1.1 billion for comparative effectiveness research (CER). CER compares treatments and strategies to improve health. This information is essential for clinicians and patients to decide on the best treatment. It also enables our nation to improve the health of communities and the performance of the health system, overall.

**Transparency Initiatives:** Provides members with clinical quality and efficiency information to make better informed decisions to access providers with a higher level of quality.

• Aetna’s informatics tools provide hospital quality information so that members can make informed provider service decisions; some states require quality ratings for certain procedures (e.g., NY for cardiac surgery).

• Research demonstrates that enrollees in consumer directed plans “are more likely than those in comprehensive plans to ask providers about costs, to identify and consider treatment alternatives, and to pay attention to wellness and prevention practices. They are also more likely to check plan coverage before seeking care, discuss costs and options with physicians, ask for less costly drugs, check quality ratings, and ask about service prices.”

**Clinical pharmacy activities:** Includes therapeutic effectiveness assessments (e.g., P&T Committee), drug interaction monitoring and direct pharmacy services (e.g., mail order delivery, specialty pharmacy delivery). These services facilitate the ability to prevent negative drug interactions, provider prescription errors and other issues that could negatively impact patients’ health.

• In 1993 medication errors are estimated to have accounted for about 7,000 deaths. Medication errors account for one out of 131 outpatient deaths and one out of 854 inpatient deaths.

• UCLA and Kaiser Permanente researchers found that 84.7% of patients who received their medications by mail at least two-thirds of the time stuck to their physician-prescribed regimen, compared with 76.9% of those who picked up their medications at traditional “brick-and-mortar” Kaiser Permanente pharmacies.

**Direct care delivery:** Includes on-site clinics, drug dispensing and other clinical services provided or arranged directly by the health plan.

**Pilot Programs and Research:** Insurers establish pilot programs to further wellness and health care quality as well as contribute to academic research to identify best practices and other initiatives to improve quality.

**Rationale:** The statute does not define “quality” and the types of activities that constitute quality for MLR purposes should be defined broadly. This would be entirely consistent with the PPACA, which encourages, and at times, broadly mandates, quality initiatives. See, e.g., PHSYA § 2717; PPACA § 1311(g) (1) as well as Sections 3011 and 3013. The activities above are good examples of already existing quality initiatives and are designed to assure that consumers get the best care at the best time -- which leads to higher overall quality of health care. Some of these activities improve quality through information sharing, while others work to reduce medical errors, improve provider services, or protect consumers from problematic services. Ultimately, these functions lead to better outcomes and lower premiums. Many organizations
recognize these types of activities as quality enhancing -- such as the NCQA, the National Quality Forum, the Leapfrog Group as well as Statutory Accounting Principle (SAP) 85. Narrowly defining quality for MLR purposes will be short-sighted and discourage insurers from developing and adopting innovative consumer quality initiatives that benefit everyone.

**Part B: Clinical Services**

This term should be based on NAIC’s definitions of claims and claims-related expenses as described in its various statutory accounting standards as permitted medical costs. Specifically, Clinical Services should include:

- **Reimbursements to health care providers**: Covers services provided to members, including fee-for-service payments, capitation, quality and other performance incentives.

- **Payments to third parties**: Costs associated with arranging favorable provider reimbursement rates, including network access fees and payments to IPAs, PHOs and other intermediaries who arrange for health care services.

- **Other categories of provider payment**: Includes contracting, credentialing, quality, cost and satisfaction measurement and reporting, communication, electronic connectivity and appeals. These costs assure an ongoing level of quality within provider networks.

- **Incurred Loss Plus Loss Adjustment Expense**: Incurred Loss and Loss Adjustment Expense, as included in the legislation, are defined in statutory accounting standards and currently reported annually by insurers. The definition of these items should be consistent with the relevant statutory accounting standards (specifically SAP 50, 54, 55 and 85) and include actual clinical claims paid, claims incurred but not yet reported or paid, estimated claims to be paid pursuant to actuarial standards (i.e., claim and premium reserves) and the cost containment expenses included as component of claim adjustment expenses and enumerated in SAP 85.

The SAP 85 expenses include case management activities, utilization review, detection and prevention of fraud, network access fees, internal and external costs related to network development and provider contracting, consumer education relating to health improvement including smoking cessation and disease management programs, and HIT costs including hardware and software creation and maintenance. All of these support quality improvement.

**Rationale**: PPACA does not define clinical services for purposes of the MLR requirement. As such, HHS has flexibility in defining this term in a manner that recognizes that different insurers contract with and pay providers in different ways. The type of physician financial arrangement (e.g., staff model HMOs, capitation) determines whether under traditional rules these administrative costs are attributed to the physician or the insurer and, in turn, determine whether those costs are included in the MLR calculation. HMOs with very narrow networks (e.g., staff models) will tend to incur lower administrative expenses under this methodology. To assure a level playing field and support the ability of both models to provide quality health services to consumers, all four items listed above -- provider reimbursements, payments to third parties, incurred loss plus loss adjustment expenses and other categories of provider payment -- should be considered under the category of clinical services costs.

The "general rule" of section 2718(a) of the PHSA is that insurers must "submit a report" to HHS regarding the ratio of incurred loss plus loss adjustment expense to earned premiums. This
general rule is amplified by the requirement that the "report" include the percentage of premium revenue that such coverage expends on the three categories listed in (a)(1) through (3) (relating to claims, quality and administrative costs).

The rebate provision in section 2718(b) builds on the calculation in 2718(a). It is true that section 2718(b) does not specifically refer to the general rule to report incurred loss plus loss adjustment expense to earned premiums. Instead, it simply refers to the ratio of (a)(1) and (2) to premium revenue. However, by referencing (a)(1) and (2) the statute imports into 2718(b) the same method by which (a)(1) and (2) are calculated for purposes of 2718(a), which should include the general rule providing for the use of the loss adjustment expense. This is because (a)(1) and (a)(2) are not stand alone provisions – they are elaborations of the general rule in 2718(a), which requires reporting that takes into account loss adjustment expenses.

This construction is supported by the fact that it would be illogical for Congress to require a report of MLR based on a different calculation method than the rebate requirement. Generally statutes, particularly sections of a statute, are read consistently absent clear evidence to the contrary. Moreover, if the methods in section 2718(a) and (b) were different, an insurer could file a report with the HHS showing it has an 89% MLR in the group market, but it might have to pay a rebate if the rebate calculation were below 85%. In such a case, the amount and fact of the rebate would be unknown to the HHS since the original report, calculated using a different method, would not reveal it. This undermines the ability of the HHS to monitor and enforce the rebate provision and cannot be what Congress intended.

**Recommendation #2: Scope of Benefits**

HIPAA excepted benefits are not subject to Minimum Loss Ratio Rules.

These HIPAA excepted benefits include:

- Coverage only for accident, or disability income insurance, or any combination thereof
- Coverage issued as a supplement to liability insurance
- Liability insurance, including general liability insurance and automobile liability insurance
- Workers’ compensation or similar insurance
- Automobile medical payment insurance
- Credit-only insurance
- Coverage for on-site medical clinics
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits

**Benefits not subject to requirements if offered separately**

- Limited scope dental or vision benefits
- Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof
- Such other similar, limited benefits, as are specified in regulations

**Benefits not subject to requirements if offered as independent, noncoordinated benefits**

- Coverage only for a specified disease or illness
- Hospital indemnity or other fixed indemnity insurance

**Benefits not subject to requirements if offered as separate insurance policy**
• Medicare supplemental health insurance, coverage supplemental to the coverage provided under chapter 55 of title 10, and similar supplemental coverage provided to coverage under a group health plan

**Rationale:** The MLR requirements apply to "group and individual health insurance coverage." Those terms are specifically defined in the Public Health Service Act and "excepted benefits" are specifically excluded from those terms (PHSA §§ 2722, 2791). This "excepted benefits" framework was maintained with respect to PPACA. As such, the MLR rules do not apply to excepted benefits. Moreover, subjecting these policies to minimum loss ratio rules could thwart their ability to offer critical products to consumers that allow them to access a quality of health services they could not access without coverage.

**Recommendation #3: Exclusion of State and Federal Costs**

The formula to calculate the minimum loss ratio should exclude state and federal assessments, taxes and other costs from premium revenue. This should include items such as federal income taxes, federal excise taxes and other federal regulatory related costs. In addition, state premium taxes, income taxes, property taxes and other regulatory and licensing fees and assessments, such as guarantee fund assessments, charity care assessments, high risk pool assessments etc., should be excluded from premium revenue. This would include items such as New York’s HCRA surcharge or the costs associated with normalizing risks such as NYS regulation146 insurer funded reinsurance pool.

**Rationale:** The MLR rule permits insurers to exclude from the non-claim cost category "federal and state taxes and licensing or regulatory fees." This is broadly worded and, as such, can be comfortably construed to cover any federal or state tax directly paid by an insurer (e.g., income taxes), as well as any tax rolled into the insured's premium (e.g., state premium taxes). It is also broad enough to cover "assessments" paid to states to fund various state programs. See Black's Law Dictionary 6th Ed. (1990) (definitions of "tax" and "assess") ("... taxes undoubtedly include assessments, and the right to impose assessments has its foundation in the taxing power of government ... "). Indeed, "assess" is defined as "to tax".; see also De Buono v. NYSA-ILA Medical and Clinical Services Fund, 520 U.S. 806, 809 (1997). The statute clearly intends to exclude these items from the calculation. If the items are not excluded, then it would reduce – or eliminate – the ability of insurers to invest in important services that further quality improvement such as health information technology, which would, in turn, frustrate the purposes of the statute to reduce costs and improve quality.
II. Enhancement of Competition

Recommendation #4: Appropriate Aggregation

For purposes of reporting and calculating MLRs, the large group should be measured at the holding company level for the largest geographic area covered.

**Rationale:** Aggregating large groups in this manner will reflect the fact that consumer needs vary based on market segment.

Large groups have membership across many states and often prefer to have a single carrier. Over 89% of groups have multiple sites. Blending large group experience across the holding company level is the most accurate way to assure reasonable distribution across all group clients—and best conforms to the accounting principle of matching costs to associated premiums.

Economist James Robinson says: "This obscure statistic [the MLR] is losing whatever meaning it once had." He notes one particular issue with the MLR as: "Efforts to compute the medical loss ratio for any one geographic region require the parent company to allocate central administrative expenses to particular regions. This is particularly problematic when some products, such as those for federal employees or large corporations, are marketed and managed at the national level."

Any requirement to calculate large group MLRs at the state level would increase administrative costs to employers and would reduce the number of insurers capable of serving this marketplace.

We note that the MLR rule does not specifically address aggregation for purposes of MLR reporting or rebate payments. Because of the statute's silence, the HHS has substantial discretion to allow aggregation by market segment (individual, small group, large group, or combined segments), as well as aggregation by state or nationally. The HHS' regulation would receive deference under settled principles of administrative law.

Recommendation #5: Credibility Allowances

The American Academy of Actuaries should modify the Medigap Credibility Table to apply to under age 65 health insurance coverage.

**Rationale:** Section 2718 does not specifically require or preclude aggregation for purposes of reporting or rebate payments. Because of the statute's silence, the NAIC and the federal agencies have substantial discretion to allow aggregation by market segment. It is bad public policy to start with a required level of aggregation that both industry and regulators understand will create ratios that have no credibility. The proposed adjustment would recognize the random variation and difficulty in accurately predicting the MLR of small, diverse populations.

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1 Review of agency action takes two steps. The first step is whether Congress has "directly spoken to the precise question at issue." *Chevron v. Nat'l Resources Defense Council*, 467 U.S. 837, 842 (1984). If so, "that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Id.* at 842-43. Where, as in the case of the MLR aggregation issue, the statute is silent or ambiguous, "the reviewing court must defer to the agency's construction of the statute, so long as it is reasonable." *Mineral Policy Center v. Norton*, 292 F. Supp. 2d 30, 37 (D.D.C. 2003).
If a credibility adjustment is not included in the MLR calculation, it could force insurers to face solvency challenges or not enter new states. This will leave consumers with less affordable coverage options due to the lack of market competition.

The level of aggregation should be coordinated with a credibility approach which reduces the effect of statistical fluctuations on the rebate calculations and is consistent with the manner in which experience is used in the re-pricing of health insurance.

Blocks of individual policies and small group policies may be credible in some states, and not credible in others, or they may be credible within one reporting entity and not in another affiliate. A flexible process for aggregation should be developed to (i) insure that the credibility standard is reached as quickly as possible for all policyholders so that valid rebates are paid and not deferred, (ii) reduce the potential for paying rebates based solely on statistical fluctuations in year-by-year experience, (iii) allow the use of appropriate risk management within carriers and companies so that risk margins do not need to be increased to reflect greater solvency risk from excessive rebates over a number of years and (iv) allow carriers and companies to coordinate the development of premiums and reasonable premium increases based on their accumulating experience in a manner as close as possible to the experience reported for section 2718 reporting.

One way to accomplish this is to adopt a modified version of the credibility adjustment table that is included in the NAIC Annual Medicare Supplement Refund Calculation form to factor in a non-Medicare population. This table would need to be updated by the American Academy of Actuaries to reflect the differences between the senior and under 65 population – and Medigap and comprehensive health care coverage. For instance, credibility would occur at a higher level than under the Medigap table. The MLR standards are intended to drive value for consumers by assuring more premium dollars go to patient care costs and reduce insurers’ administrative expenses. These standards, however, must guard against the unintended effect of causing volatility that could drive up the cost of health insurance coverage for consumers and reduce their choices in the marketplace. New regulations should build on the experience and lessons learned from the calculations designed for the NAIC Medicare Supplement loss ratio standards. Those standards recognized uncertainties and market selection dynamics. However, the standard for the commercial health insurance market must be adjusted to factor in the diversity and wider variation of claims costs in this population as well as comprehensive benefit plans.

The minimum MLR standards in the new federal law guarantee consumers a rebate if the standards are not met, but provide no protection against random variation in claims experience. Based upon the NAIC’s past methodology, credibility refers to having a sufficient number of covered lives within a state. If an insurer has low membership, its block of business is too small and the experience will not be credible. Health claims are not predictable and can vary significantly from year to year depending on the insurer’s volume of business.

The NAIC methodology addressed some of the claim variation by adopting a credibility or tolerance adjustment to the MLR based on the number of policyholders and the length of time they held their policies. No rebate was required if the policy loss ratio was based on less than 500 life-years exposure. The rationale for this adjustment was to ensure that rebates would not occur so frequently in the early years of the policy experience that large premium increases could result in later years.

Additionally, the ability of new insurers to enter markets, or existing insurers to develop new, innovative products will be stifled without a minimum size threshold. In the initial phases of a product life cycle, pricing is difficult to determine (in any industry); the proposed credibility table
will allow for appropriate pricing adjustments, ensuring attainment of minimum loss ratio requirements, as product sales grow and mature.

**Recommendation #6: Market Monitoring**

Specify that state and federal regulators should monitor the impact of MLR requirements and intervene if market destabilization occurs. In particular, the federal government should lower MLR requirements in the following situations:

- **Early Solvency Warning**: An early warning trigger should be if multiple insurers slip to risk based capital levels that are considered by the NAIC as early warning stages. If this trigger occurs, the MLR should be lowered to avoid the bankruptcy of insurers -- and the harm that would bring to consumers and providers.

- **Product Compression**: Another trigger should be if at least 10% of products are withdrawn from the marketplace.

- **Market Contraction**: Another trigger should be if at least 10% of enrollees in the marketplace are impacted by one or more insurers exiting the market. In this case the individual market should be considered destabilized and the Secretary should lower the MLR requirements.

**Rationale**: According to the American Academy of Actuaries, “Imposing unrealistically high medical loss ratio requirements may threaten plan solvency by making it difficult for premiums to cover claims and expenses.” In addition, if the MLR is set too high, carriers will exit the market. This undermines one of the stated goals of reform – to allow consumers to “keep what they have.” In addition, it would reduce consumer choice and competition in many states. CBO has also noted the possibility of insurers exiting the individual market. State experience supports this as well. At one point in the 1990s, residents in 36 of 39 Washington State counties were left without access to individual market coverage because of shortsighted state insurance reforms. Having early warning triggers are critical to avoid this.

**Recommendation #7: Transitional Rules on Rolling Averages**

Reporting, calculation and rebating of MLRs should be done on a three year rolling average per state. Beginning in 2011, the Secretary should allow insurers to use a three year rolling average when calculating their MLR.

**Rationale**: The timeframe (e.g., multi-year, lifetime, annual) over which included costs and claims occur will have a significant impact on the MLR, since high cost investments and the savings they generate may not accrue in the same time period. In addition, administrative costs for a product vary over time. For instance, launching a new product may require more administrative costs than in later years when the product is simply being maintained. Basing the allocation on a three year rolling calculation will also help to smooth out fluctuation in smaller blocks of business. If single years are required for MLR calculations, it would reduce the ability of new insurers to enter a marketplace or to existing insurers to roll out new products.

**Recommendation #8: Transitional Rules on Broker Commissions**
Allow a portion of broker commissions to be excluded from premium revenue on a transitional basis. 90% of external commissions would be excluded from premium in the 2011 MLR calculation. This exclusion would be reduced to 66% in 2012, 33% in 2013, and 0% in 2014.

**Rationale:** Many insurers have contracts with brokers that were established prior to PPACA passage and are in effect for 2010. Some longer term contracts may stretch beyond 2010 into 2011 and 2012. These new MLR levels were established based on changes that would occur in the reformed market of 2014 – such as the elimination of underwriting, an individual mandate, and the establishment of the exchange.

Prior to 2014, the administrative cost structure of insurers will not benefit from health care reform initiatives. In a recent letter to Congress, the National Association of Insurance Commissioners references this by saying: “...80% in the individual market may not be readily achievable by many insurers. These companies have already entered into contracts with agents and brokers that obligate them to pay specified levels of commission and have expenses associated with underwriting and marketing that they will not be able to reduce until guarantee issue requirements and health insurance exchanges are implemented.”
III. Administrative Efficiency

Recommendation #9: Calendar Years

MLRs should be reported and calculated on a calendar year basis.

Rationale: The NAIC is given broad authority to set definitions in this section. Most states base MLR calculations on a calendar year basis. The PPACA requires MLR calculations to be based on the "plan year." Requiring insurers to calculate and report to states on a calendar year basis and to the federal government on a plan year basis would increase administrative costs, create difficult to reconcile results, and could lead to confusion for individuals using this information to compare policies. Many groups (even those enrolled in the same product line) could have different plan years. This could result in thousands of MLR calculations per insurer throughout the year. Further, the individual market traditionally doesn’t use the term “plan year.” Instead, consumers generally have “renewal dates” -- with thousands of customers renewing every day of the calendar year. Moreover, customers are accustomed to thinking about insurance in deductible years (usually calendar years), not plan years. To avoid additional administrative costs and confusion, the most appropriate and sensible period should apply—the calendar year.

We note that this interpretation can be reconciled with the term "plan year" as it has been interpreted by the HHS under the PHSA's group market rules for insured plans. See 45 C.F.R. Sec. 144.103. More specifically, plan year is defined as follows –

[T]he year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is— (1) The deductible or limit year used under the plan; (2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year; (3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer’s taxable year; or (4) In any other case, the plan year is the calendar year.

45 CFR § 144.103: For most insured group business and all individual insurance, there are no separate written plan documents that designate a plan year (most insured ERISA plans just use the group policy and an SPD supplement). As such, consistent with the regulation, the HHS can and should look to the period during which deductibles accumulate, which is typically a calendar year.

Recommendation #10: Rebates

The regulation should provide for a fair and administratively efficient mechanism to protect consumers from insurers who fail to comply with minimum loss ratio requirements. The rebate or “penalty” process should:

- Provide Premium Credits: Currently enrolled individuals and employers (on behalf of their enrollees) would receive premium credits toward their payments.
- Provide reasonable timing: For rebates given directly to individuals, premium credits should be issued within four months after the MLR report is submitted.
- For all markets: NAIC would establish a de minimus rule where premium credits would not be made. Instead, an aggregate contribution to the state high risk pool or risk adjustment mechanism would occur.
**Rationale:** These suggestions are based on states already requiring rebates (e.g., NJ, NM, NY) – where many allow premium credits as an administratively efficient way to issue rebates. Issuing rebates to individual members is administratively costly, as insurers must locate former members that have since dropped coverage and changed location as well as perform the administratively costly “cutting of checks.” If rebates for small amounts are required to be issued, the administrative cost could exceed the value of the checks to consumers. A rule that allows insurers to reduce policyholder premiums by applying rebates to outstanding premiums as a means of dealing with small distributions would be consistent with the way similar issues have been resolved by regulators. For example, the Department of Labor indicated that plan fiduciaries could use settlement proceeds to pay plan expenses if it would not be cost effective to allocate the proceeds to participant accounts (DOL FAB 2006-01).

To require direct payment of small rebates to consumers would have the paradoxical impact of increasing administrative costs and consumer premiums. Providing this aggregate rebate amount to a state entity – such as a high risk pool or risk adjustment mechanism – would benefit all consumers in the market, be administratively efficient, and still act as a “penalty” to insurers that would encourage compliance with the MLR rules.

**Recommendation #11: Preemption**

Federal Minimum Loss Ratio reporting and rebate rules should preempt state minimum loss ratio rules.

**Rationale:** PPACA minimum loss ratio rules are part of the overall HIPAA framework that preempts state laws that prevent the application of the federal law (PHSA § 2723(a)). As a practical matter, if states have different MLR formulas and rebate requirements, these rules would conflict with federal rules. Insurers can only rebate a dollar once...you cannot rebate the same dollar twice. Consistent with the statute and current practice, the PHSA preemption scheme should preempt those state laws to the extent that the state law prevents the application of the federal MLR standard (PHSA § 2724(a)). In addition, on a purely pragmatic level, conflicting state MLR rules would create unnecessary administrative costs and increase consumer premiums and would thus frustrate one of the goals of the PPACA.

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4 Medical Management Guide, Office of the Assistant Secretary of Defense for Health Affairs and Office of the Chief Medical Officer, Population Health and Medical Management Division.
5 "Washington State Department of Labor and Industry, see http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/UtilReview/default.asp
6 http://www.socialsecurity.gov/history/ssa/lbjmedicare4.html.
Molina Healthcare
National MCR Reform Discussion

The Request for Information regarding Section 2718 of the Public Health Service Act prepared by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services directs the NAIC to define which activities improve health care quality.

We, at Molina Healthcare, believe **Quality Improvement activities** must include, at a minimum, the following efforts:

- Usage of Health Risk Assessments and predictive modeling to identify needy members early.
- Management of continuum from prevention to catastrophic care including chronic condition and co-morbidity management.
- Wellness programs such as preventive care; screening tests; annual visits; flu and other immunizations; smoking cessation; health education; diet and nutrition; EPSDT.
- 24/7 Nurse Advice Line (NAL) which provides education, advice, appropriate use of services/locations of service, and triage to other programs.
- Maternity and Neonatal Care including member and provider education; 17-P program; early identification; risk assessment; case management; postpartum care; infant car seat program; triage to other programs.
- Disease Management / Case Management programs including identification of relevant conditions; identification, stratification, monitoring and management of affected members; education of members and providers on use of DM/CM services; measuring effectiveness; and ensuring timeliness of referrals.
- Complex Case Management and Care Coordination in which the plan coordinates services for members with complex conditions such as transportation, community services, Medical Home establishment (including care transitions post discharge, post ED visit), and overall continuity of care (care transitions and data exchange between medical, behavioral health, acute and long term care providers).
- Medical Case Management including transitional and catastrophic care.
- Medication Therapy Management including polypharmacy; compliance with dosing, gaps in refills, adverse interactions, and extreme use of controlled substances.

- Member and provider health education.
- Ensuring safe points of service at offices/hospitals.
- “Never Events” monitoring and management.
- Promotion of safe medication use.
- Monitoring and Management of underutilization and overutilization of services.
- Centers of excellence for specialized services/care.
- Ensuring standards of medical record keeping/documentation are met.
- Collaboration on member care plans to ensure that individuals can remain safely in their home or in the least restrictive setting.

- Assessment of the cultural and linguistic needs of members.
- Ensuring an adequate supply of providers who are educated about and meet the cultural and linguistic needs of members.
Credentialing of providers and facilities.
- Inspection of provider facilities.
- Quality monitoring including peer review.

Provider performance measurement and tracking.
- Promotion and implementation of pay-for-performance programs.
- Oversight of delegated entities through assessment, corrective action plans, review and continuous monitoring.
- Investigation, resolution, validation, and prevention of quality of care complaints in a timely and complete manner.

Appointment access record audits.
- Analysis of appointment access and timeliness via complaints and appeals, member surveys, CAHPS, and member Service phone standards performance.

Adoption and distribution of Preventive Health Guidelines and monitoring of outcomes.
- Adoption and distribution of evidence-based Clinical Practice Guidelines and performance measurement.
- Distribution of Medical Coverage Guidance and performing research and creating policies to apply decisions on experimental and investigational procedures, pharmaceuticals, medical devices or mental health technologies.

Ensuring a broad monitoring mechanism to identify opportunities, adoption of targeted interventions, results monitoring and resolution of barriers to affect meaningful improvement;
- Ensuring member satisfaction with service, providers, plan and plan programs.
- Monitoring and identifying opportunities through HEDIS, CAHPS, appeals and grievances, member surveys, various clinical and service touch-points, e.g., Member Services, nurse advice line, utilization management, disease management, care management.

Usage of HEDIS performance to identify and monitor outcomes and target intervention for underutilization and clinical improvement. The majority of states require health plan use of HEDIS to measure performance on dimensions of care and service.

Ensuring NCQA accreditation. States often use NCQA accreditation as a surrogate for quality and require it as condition of participation.
- QI program development and planning and implementation at enterprise and health plan levels.
- Providing systems to support quality-related operations, public data and reporting, accreditation/HEDIS.
Taxes and Fees

In addition, the Patient Protection and Affordable Care Act (PPACA) requires that each report submitted to the Secretary include the percentage of total premium revenue – after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance – that the coverage spends:

(1) on reimbursement for clinical services provided to enrollees under such coverage;
(2) for activities that improve health care quality; and
(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding *Federal and State taxes and licensing or regulatory fees* [emphasis added].

We believe that such taxes and fees should include:

- State and federal taxes
- Provider taxes, fees, assessments and charges
- Quality taxes, fees, assessments and charges
- Pass-through payments to third parties
- Insurance fund assessments and payments
- High risk pool assessments and payments
- Indigent care assessments and payments
May 4, 2010

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

Re: Medical Loss Ratios – Section 2718 of the Public Health Service Act (PHSA)

Dear Mr. Felice:

I am writing to offer comments to National Association of Insurance Commissioners (NAIC) regulators and representatives as you consider classification of health plan expenses related to the calculation of Medical Loss Ratio (MLR) – in particular the services you consider to be those that improve population health.

The National Committee for Quality Assurance (NCQA) is a private, nonprofit organization dedicated to improve the quality of health care. Our organization began 20 years ago with a focus on accrediting health plans and quickly moved to incorporate a set of performance measures – called HEDIS measures – into the accreditation process. HEDIS measures are the most widely used quality measures for health plans – they are used by employers for the commercial market, Medicare and Medicaid plans, and in state initiatives around quality reporting and report cards. In 2009, a total of 979 health plan products (702 health maintenance organizations and 277 preferred provider organization products) submitted audited HEDIS data to NCQA. These plans cover 116 million Americans, or 2 in 5 people.

In addition to operating our longstanding accreditation programs for health plans, NCQA also accredits or has recognition programs for other types of health organizations, including physicians and physician groups, managed behavioral healthcare organizations and disease management organizations. All of these programs build standards and performance measures based on a rigorous process that relies on multi-stakeholder expertise, the latest and the most robust evidence and a transparent process that includes public comment. Examples of our health plan accreditation standards and measures are included as an attachment to this letter. We also collect and report health quality information for a variety of audiences that want to challenge providers and plans to improve their performance through benchmarking, and to inform consumers and others about the highest performing providers. We have dedicated our organization to improving quality, and our processes and measures have led to results that have saved lives and prevented illness and the costs associated with poor quality. For example, we estimate that performance measurement has improved care for diabetes, heart disease, high blood pressure and high cholesterol, this saves 165,000 to 272,000 lives.
NCQA strongly supported the statutory provision to include activities that improve health care quality together with clinical services in calculating the medical loss ratio. In our experience, activities that improve health care quality would encompass expenses related to:

- wellness and health promotion,
- care coordination,
- disease management,
- accreditation,
- activities supporting health information technology and
- reporting quality measures

All of these activities represent investments that can lead not only to higher quality but better value in health care spending on clinical services. Health plans that invest in prevention – for example through appropriate immunizations and tobacco cessation counseling—will have healthier enrollees, whose spending on health care services should be lower over the long run. Credentialing connects to strategies to improve diagnosis and treatment of disease as board certification and recertification standards have evolved. A 2005 article in the Journal of the American Medical Association, for example, found a positive association between the rate at which preventive care services were delivered for Medicare patients and certification status in internal medicine or family medicine. Further, these types of services are clearly intended to improve the health of populations, and do not represent funds available to the plan for profit, reserves, marketing or other administrative expenses.

We appreciate the opportunity to comment on this issue. If you have questions about NCQA’s accreditation or performance measurement programs, we would welcome the opportunity to present to the committee or to have a discussion with you. Please do not hesitate to contact me or Sarah Thomas, Vice President of Public Policy and Communications at (202) 955-1705.

Sincerely,

Margaret O’Kane
President

Attachment

cc: Richard Diamond, Chair, Actuarial MLR Subgroup
    Todd Sells, NAIC Staff
    John Englehart, NAIC Staff
    Brian Webb, NAIC Staff
Achieving Improvement Through Measurement

NCQA Health Plan Accreditation includes two major components on which a plan’s performance is scored: standards, an evaluation of the plan’s structure and processes to maintain and improve quality in five core areas; and Healthcare Effectiveness Data and Information Set (HEDIS®), an evaluation of the plan’s performance on process and outcomes in clinical care and patient experience of care.

NCQA standards evaluate the following categories:

**Quality Management and Improvement**
- A health plan’s systems for continuous improvement of quality of care and service.
- How the plan makes sure that members have access to the care they need.
- Specific plan programs that help members with chronic illnesses (e.g., disease management and complex illness or trauma; case management).

**Utilization Management**
- How fair, consistent and prompt is the plan when it makes decisions about medical necessity for medical, behavioral health and pharmacy services?
- Does the plan use evidence-based clinical guidelines and clinical staff—including physicians—to make decisions?
- Does the plan have a process for members to appeal its medical necessity and coverage decisions?

**Credentialing**
- How thoroughly the plan investigates qualifications and practice history before allowing a physician to join its network.
- The plan’s process for ongoing evaluation of the physicians in its network.

**Members’ Rights and Responsibilities**
- Does the plan clearly inform its members about how to get care and use its services?
- Does the plan have a process to respond to member concerns and complaints?
- How the plan protects members’ personal information.

**Member Connections**
- How the plan distributes important information to members, such as their health status, plan resources, member care options and the cost of different services and prescription drugs.
- How the plan promotes wellness and prevention to its members.

HEDIS measures evaluate areas of care.
- Preventive services, such as child and adult immunizations, cancer screenings, prenatal care and smoking cessation.
- Treatment of acute illnesses, such as respiratory infection and pharyngitis in children and bronchitis in adults.
- Management of chronic illnesses, such as diabetes, high cholesterol, high blood pressure, asthma and depression.
- Patient experience: with the services provided by the plan and by the physicians in the plan’s network: how quickly members can access care, how members rate their personal physician, the claims process, customer service and overall rating of the plan.

NCQA’s rigorous survey process consists of onsite and offsite evaluations conducted by a team of physicians and managed care experts. The offsite survey reviews the plan’s self-evaluation and other materials submitted to NCQA through the Interactive Survey System (ISS), the first Web-based tool for health plan accreditation. The ISS provides guidance and feedback to the plan while it performs a survey-readiness evaluation against NCQA Accreditation standards. The survey team reviews the plan’s submitted documentation for compliance with the standards.

The onsite survey is a two-day visit, during which NCQA surveyors interview plan staff and review materials that cannot be submitted via the ISS, such as actual case records, meeting minutes and other confidential documents.

\(^1\) HEDIS\(^\text{®} \) is a registered trademark of the National Committee for Quality Assurance (NCQA).
\(^2\) Based on CAHPS\(^\text{®} \) (Consumer Assessment of Healthcare Providers and Systems), a standardized survey used by all plans.
\(^3\) CAHPS\(^\text{®} \) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

DATE: ________________

CONTACT PERSON: ________________________________

TELEPHONE: ________________________________

EMAIL ADDRESS: ________________________________

ON BEHALF OF: Health Reform Solvency Impact (E) Subgroup

NAME: Lou Felice

TITLE: Chair of the Subgroup

AFFILIATION: New York State Department of Insurance

ADDRESS: 25 Beaver Street

New York City, NY 10004

FOR NAIC USE ONLY

Agenda Item # ____________

Year ____________

Changes to Existing Reporting [ ]

New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ ]

Modifies Required Disclosure [ ]

DATE:

CONTACT PERSON:

TELEPHONE:

EMAIL ADDRESS:

ON BEHALF OF: Health Reform Solvency Impact (E) Subgroup

NAME: Lou Felice

TITLE: Chair of the Subgroup

AFFILIATION: New York State Department of Insurance

ADDRESS: 25 Beaver Street

New York City, NY 10004

DISPOSITION

[ ] Rejected For Public Comment

[ ] Referred To Another NAIC Group

[ ] Received For Public Comment

[ ] Adopted Date ____________

[ ] Rejected Date ____________

[ ] Deferred Date ____________

[ ] Other (Specify) ____________

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT

[ X ] INSTRUCTIONS

[ X ] CROSSCHECKS

[ X ] BLANK

[ X ] Life and Accident & Health

[ X ] Property/Casualty

[ X ] Health

[ ] Separate Accounts

[ X ] Fraternal

[ ] Title

[ ] Other Specify

Anticipated Effective Date: Annual 2010, Quarterly 2011

IDENTIFICATION OF ITEM(S) TO CHANGE

Add a new supplement and instructions for the recording of comprehensive major medical health insurance business for large group employer, small group employer, and individual.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

To assist regulators in identifying and analyzing the medical loss ratio for comprehensive major medical health insurance as required in the Patient Protection and Affordable Care Act (PPACA) of 2009 (H.R. 3590).

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: ________________________________

Other Comments:

** This section must be completed on all forms.

Revised 6/13/2009

ANNUAL STATEMENT FOR THE YEAR 2010 OF THE

© 2010 National Association of Insurance Commissioners
**SUPPLEMENTAL HEALTH CARE EXHIBIT** *(Due July 1 following the end of the Calendar Year)*

REPORT FOR: 1. CORPORATION _________________________________________________  
2. _____________________________________________ ______________________________________

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<td>1.4 Federal income and Other Taxes</td>
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<td>1.5 State premium taxes</td>
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<td>1.6 Regulatory authority licenses and fees</td>
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<td>1.7 Adjusted Premiums Earned (Lines 1.1+1.2+1.3 - 1.4+1.5)</td>
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<td>2. Claims</td>
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<td>2.1 Incurred claims excluding prescription drugs</td>
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<td>2.3 Pharmaceutical rebates</td>
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<td>2.4 State assessment for stop loss, market stabilization and high risk pools</td>
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<td>3. Incurred medical incentive pools and bonuses</td>
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<td>4. Total Incurred Claims (Line 2.1+2.2+2.3-2.4+2.5)</td>
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<td>5. Improving health care quality expenses incurred</td>
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<td>5.1 Type A. Health care quality expenses incurred including cost containment</td>
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<td>5.2 Type B. Other health care quality expenses</td>
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<td>5.5 Total Improving health care quality (Line 5.1+5.2+5.3+5.4)</td>
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<td>6. Medical Loss Ratio (Line 4+5.5) Line 1.7</td>
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<td>6.1 Adjustment for Credibility</td>
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<td>6.2 Adjustment for Newer Benefit Plan</td>
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<td>6.3 Reported Actual MLR prior to Rebates (Line 6+6.1+6.2)</td>
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<td>7. Claims adjustment expenses</td>
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<td>7.1 Cost containment not included in quality of care Line 5</td>
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<td>7.2 All other claims adjustment expenses</td>
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<td>7.3 Total claims adjustment expenses (Line 7.1+7.2)</td>
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<td>8. Sales general &amp; administrative expenses</td>
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<td>8.1 Direct sales salaries, force salaries and benefits</td>
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<td>8.2 Agents and brokers fees and commissions</td>
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<td>8.3 Other taxes (excluding Federal Income Tax)</td>
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<td>8.4 Other sales general and administrative expenses</td>
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<td>8.5 Total sales general and administrative (Line 8.1+8.2+8.3+8.4)</td>
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<td>9. Underwriting Gain/Loss (Line 1.7+1.8+2.5-7.3+8.5)</td>
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<td>10. Net investment and other gain (loss)</td>
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<td>11. Federal income taxes not included in line 13</td>
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<td>12. Net gain or loss (Line 9+10+11)</td>
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<td>13. Rebates Paid in Year for Prior Years</td>
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**REBATE PERCENTAGE DETERMINATION**

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
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<tbody>
<tr>
<td>14.1</td>
<td>Adjusted Actual MLRs for Prior Years</td>
</tr>
<tr>
<td>14.1.1</td>
<td>Immediately Prior Year</td>
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<tr>
<td>14.1.1.1</td>
<td>Reported MLR (line 6.3 from Prior Year Report)</td>
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<tr>
<td>14.1.1.2</td>
<td>Rebates Paid for Prior Year (from line 13)</td>
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<tr>
<td>14.1.3</td>
<td>Adjusted Earned Premium (line 1.7 from Prior Year Report)</td>
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<tr>
<td>14.1.4</td>
<td>Rebate Paid Percentage (line 14.1.2/line 14.1.3)</td>
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<tr>
<td>14.1.5</td>
<td>Adjusted Actual MLR for Prior Year (line 14.1.1 + 14.1.4)</td>
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<tr>
<td>14.2</td>
<td>Penultimate Year</td>
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<tr>
<td>14.2.1</td>
<td>Reported MLR (line 6.3 from Penultimate Year Report)</td>
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<tr>
<td>14.2.2</td>
<td>Rebates Paid for Penultimate Year (from line 13 of Prior Year Report)</td>
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<tr>
<td>14.2.3</td>
<td>Adjusted Earned Premium (line 1.7 from Penultimate Year Report)</td>
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<tr>
<td>14.2.4</td>
<td>Rebate Paid Percentage (line 14.2.2/line 14.2.3)</td>
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<tr>
<td>14.2.5</td>
<td>Adjusted Actual MLR for Penultimate Year (line 14.2.1 + 14.2.4)</td>
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<tr>
<td>15</td>
<td>Three year Average Adjusted Actual MLR Calculation</td>
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<tr>
<td>15.1</td>
<td>Current Year Adjusted Actual (line 6.3)</td>
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<td>15.2</td>
<td>Prior Year Adjusted Actual (line 14.1.5)</td>
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<td>15.3</td>
<td>Penultimate Adjusted Actual (line 14.2.5)</td>
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<tr>
<td>15.4</td>
<td>Average Ratio for Current Year (lines 15.1+15.2+15.3/3)</td>
</tr>
<tr>
<td>16</td>
<td>Rebate Percentage for Current Year</td>
</tr>
<tr>
<td>16.1</td>
<td>MLR Required Percentage</td>
</tr>
<tr>
<td>16.2</td>
<td>Current Year Actual after three year averaging (line 15.4)</td>
</tr>
<tr>
<td>16.3</td>
<td>Current Year Rebate Required (greater of 0 and line 16.1 - line 16.2)</td>
</tr>
<tr>
<td>17</td>
<td>Rebate Amount (line 1.7 x line 16.3)</td>
</tr>
</tbody>
</table>

**OTHER INDICATORS**

1. Number of Certificates
2. Number of Covered Lives
3. Number of Plans
4. Member Months
A schedule must be prepared and submitted to each jurisdiction in which the company has written direct comprehensive major medical health business, or has direct amounts paid, incurred or unpaid for provisions of health care services. This also includes the Federal Employees Health Benefit Plan (FEHBP). In addition, a schedule must be prepared and submitted that contains the grand total (GT) for the company.

Include medical only programs that provide medical only benefits without hospital coverage (defined benefit plans or mini-meds). Does not include self-insured business, Title XVIII Medicare Title, Title XIX Medicaid, vision only and dental only business. Report these lines of business in the other health column.

Business that provides for medical coverage including hospital, surgical, & major medical, excluding State Children’s Health Insurance Program (SCHIP) Medicaid Program (Title XXI) risk contracts should be reported in the other health column.

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Individual (including grandfathered business)</th>
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<tbody>
<tr>
<td>Health insurance where the policy is issued to an individual covering the individual and/or their dependents. This includes conversions from group policies unless the premiums and claims for such policies are retained in the group line. Exclude policies reported in column 1A.</td>
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<thead>
<tr>
<th>Column 1A</th>
<th>Individual (Grandfathered)</th>
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<tbody>
<tr>
<td>Health insurances written prior to enactment of the PPACA of 2009 (HR. 3590). This should include policies issued to an individual covering the individual and/or their dependents, as well as conversions from group policies.</td>
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<thead>
<tr>
<th>Column 2</th>
<th>Small Group Employer</th>
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<tr>
<th>Column 3</th>
<th>Large Group Employer</th>
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<tr>
<th>Column 6</th>
<th>Other Health</th>
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<tbody>
<tr>
<td>All other health care business not reported in columns 1 through 4 including the State Children’s Health Insurance Program (SCHIP), Medicaid Program (Title XXI) risk contracts, Medicare Title XVIII, Medicaid Title XIX, Medicare Supplement, dental and vision only, prescription drug coverage, etc.</td>
<td></td>
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</tbody>
</table>

**Line 1.1 – Health Premiums Earned**

Include: Direct written premium plus the change in unearned premium reserves and reserve for rate credits.

The impact (plus or minus) of Assumed Reinsurance and Accepted Reinsurance

**Line 1.2 – State and Local Taxes**

Include: Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by states. Canadian and other foreign taxes are to be included appropriately.

Real estate and payroll taxes levied by a state or locality.

Advertising required by law, regulation or ruling, except advertising associated with investments.
State sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.

Any other tax or surcharge imposed generally by a state or locality.

State taxes based on policy reserves, if in lieu of premium taxes. Canadian and other foreign taxes should be included appropriately.

Exclude: Any portion of commissions or allowances on reinsurance assumed that represents specific reimbursement of premium taxes.

Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

Line 1.3 - Federal income and other taxes

Include: All federal income taxes, federal excise taxes or other fees or taxes payable to the federal government allocable to the insurance operations of the company.

All fees assessed pursuant to PPACA sections 1010 and 10907.

Line 1.4 - Regulatory Authority Licenses and Fees

Include: Assessments to defray operating expenses of any state insurance department.

Fees for examinations by state department, including charges for externally contracted examiners and specialists contracted by the state departments of insurance or departments of health for examinations.

Licensing fees for companies or agents paid by the company, rate and form filing fees, holding company filing fees or any other fee levied by state insurance or health departments on companies in order to file mandatory reporting forms, fees to obtain or renew certificates of authority, file articles of incorporation and bylaws, fees paid to file the company's annual and quarterly financial reports, fees paid to the NAIC's Securities Valuation Office in order to file annual financial reports.

Line 1.2 - State Assessments for Indigent Care or Similar Programs

Line 1.4 - State and Local Insurance Taxes

Include: Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by states. Canadian and other foreign taxes are to be included appropriately.

Advertising required by law, regulation or ruling, except advertising associated with investments.

State sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.

State income taxes.

Line 1.5 - State Premium Taxes

Include: State taxes based on policy reserves, if in lieu of premium taxes. Canadian and other foreign taxes should be included appropriately.

Exclude: Any portion of commissions or allowances on reinsurance assumed that represents specific reimbursement of premium taxes.
Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

Line 1.6 Regulatory Authority Licenses and Fees

Include: Assessments to defray operating expenses of any state insurance department.

Fees for examinations by state departments.

Exclude: Fines and penalties of regulatory authorities.

Line 2.1 – Incurred Claims Excluding Prescription Drugs:

Include: Paid Claims During the Year

Report payments net of risk share amount collected.

The impact (plus or minus) of Assumed Reinsurance and Accepted Reinsurance

Change in Unpaid Claims

Report the change between prior year and current year unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, recoverable for anticipated coordination of benefits (COB) and subrogation.

Change in Incurred but not Reported

Report the change in claims incurred but not reported from prior year to current year. Except where inapplicable, the reserve included in these lines should be based on past experience, modified to reflect current conditions, such as changes in exposure, claim frequency or severity.

Change in Contract & Other Reserves

The amount may be determined as provided in 42 CFR Chap IV (10-01-09 Edition) Section 403.253(b)

Exclude: Prescription drugs reported in line 2.2.

Pharmaceutical rebates received during the year, reported in line 2.3.

Medical incentive pools and bonuses.

Line 2.2 – Prescription Drugs

Include: Expenses for Prescription Drugs and other pharmacy benefits covered by the reporting entity.

Exclude: Prescription drug charges that are included in a hospital billing which should be classified as Hospital/Medical Benefits on Line 2.1.

Line 2.3 – Pharmaceutical Rebates

Refer to SSAP 84.

Line 2.4 – State Assessments for Stop Loss, Market Stabilization and High Risk Pools

Line 3 – Incurred Medical Incentive Pools and Bonuses

Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees
to share savings with contracted providers.

Line 5.1 – Health Care Quality Expenses Incurred Including Cost Containment

Include: See AHIP letter for the scope of the activities to be included in lines 5.1-5.4

Cost containment expenses that directly relate to quality of health care:

Case management activities and chronic disease management that are directly related to the quality of care.

Network access fees to Preferred Provider Organizations and other network-based health plans (including prescription drug networks), and allocated internal salaries and related costs associated with network development and/or provider contracting;

Consumer education solely relating to health improvement and relying on the direct involvement of health personnel (this would include smoking cessation and disease management programs, implementation of wellness and health promotion activities, and other programs that involve hands on medical education);

Exclude: Cost containment expenses that do not directly relate to the quality of health care. These are reported in line 7.1.

Line 5.2 - Other Health Care Quality Expenses

Health care expenses as allowable under the Patient Protection and Affordable Care Act of 2009 (H.R. 3590).

Include: Prevention of adverse effects of drugs and biological products;

Health care research related to quality, outcomes, cost and utilization and access to health care services;

Implementation activities to improve patient safety and reduce medical errors through appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

Line 6.1 - A percentage added to the value in line 6 to reflect the lack of statistical credibility in the underlying numbers. A table would need to be inserted with various “tolerance” percentages.

Line 6.2 - A percentage added to the value in line 6 to reflect the lower loss ratios historically reported for newer benefit plans. A table would need to be inserted with various “duration” weighted percentages.

Line 7.1 – Cost containment not included in quality of care Line 5

Include: Expenses that meet the Statutory definition of cost containment expenses but are not actually serve to reduce the number of health services provided or the cost of such services. Exclude cost containment expenses which improve the quality of health care reported in line 5.1. The following are examples of items that shall be considered “cost containment expenses” only if they result in reduced levels of costs or services:

Case management activities;

Utilization review;

Detection and prevention of payment for fraudulent requests for reimbursement;

Expenses for internal and external appeals processes.
Line 7.2 – All Other Claims Adjustment Expenses

Include: Costs expected to be incurred in connection with the adjustment and recording of accident and health claims defined in subparagraphs 6 a. and 6 b. of SSAP No. 55. Further, Claim Adjustment Expenses for Managed Care Reporting Entities are those costs expected to be incurred in connection with the adjustment and recording of managed care claims defined in subparagraph 7 a. of SSAP No. 55.

Examples of other claim adjustment expenses are:

- Estimating the amounts of losses and disbursing loss payments;
- Maintaining records, general clerical, and secretarial;
- Office maintenance, occupancy costs, utilities, and computer maintenance;
- Supervisory and executive duties; and
- Supplies and postage.

Exclude: Costs reported in lines 5.1 through 5.4

Line 8 – Sales General & Administrative Expenses

Line 8.1 – Direct Sales Salaries, Force Salaries and Benefits of Salaried Personnel involved in Sales

Line 8.2 – Agents and Brokers Fees and Commissions

Line 8.3 – Other taxes (excluding federal income tax)

Include: Guaranty fund assessments and taxes of Canada or of any other foreign country not specifically provided for elsewhere.

Sales taxes, other than state sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.

Line 8.4 – Other Sales General & Administrative Expenses

OTHER INDICATORS

Line 1 – Number of Certificates

This is the number of certificates issued to individuals covered under a group policy in force as of end of the reporting period. It is not the number of persons covered under individual policies or group certificates. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

Line 2 – Number of Covered Lives

This is the total number of lives insured, including dependents, under individual policies and group certificates as of end of the reporting period. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

Line 3 – Number of Plans

This is the total number of insurance plans issued as of the end of the reporting period.
Line 4 – Member Months

The sum of total number of lives insured on a pre-specified day of each month of the reported period. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

| Line 4.1 | Previous year’s Member Months |
| Line 4.2 | Penultimate Year’s Member Months |
| Line 4.3 | Covered Lives for Tolerance Table |

The sum of lines 4, line 4.1 and line 4.2 divided by 12.

Drafting note for discussion:
The Working Group should discuss the usefulness of a subsequent “roll forward” schedule that reflects claims run-off and reconciles to a future date. (Possibly a subsequent date when rebates would be calculated.)
May 3, 2010

Mr. Steve Oslund
Chair, Accident & Health Working Group
c/o National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

Dear Mr. Oslund;

On behalf of the Pharmaceutical Care Management Association (PCMA), we appreciate this opportunity to offer our comments as the Accident & Health Working Group and its subgroups consider the uniform definitions and standardized methodologies for calculating “medical loss ratios” (MLR) provisions of §2718 – “Bringing Down the Cost of Health Care Coverage” – of the Public Health Service Act added by the Patient Protection and Affordable Care Act (PPACA).

PCMA is the national association representing America’s pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 210 million Americans with health coverage provided through Fortune 500 employers, health insurers, labor unions, Medicare, Medicaid, and the Federal Employees Health Benefits Program.

In General

For purposes of reporting the MLR as well as determining any appropriate rebates, PCMA recommends that the definitions and methodologies remain consistent with current NAIC Accounting Practices and Procedures Manual while recognizing health care quality expenses as a separate expense category counting toward the medical loss side of the ratio. PCMA is concerned that any calculation that does not continue to include all expenses in connection with the adjustment and recording of claims and “cost containment” expenses in the “loss” portion of the ratio will create a perverse incentive for insurers to reduce the amount spent on these functions. Such activities, which serve to lower employer premiums and bring value to the health care system as a whole, include accurate and timely claims payment, fraud enforcement and prevention, case management, utilization review and other functions that lower costs or the number of unnecessary services.

We believe that it is important for the Accident and Health Working Group and its subgroups to have completed a significant amount of work on the definitions and methodologies prior to the Health Reform Solvency Impact Group completing development of the Supplemental Health Care Exhibit. This will allow the Health Reform Solvency Impact Group to have a complete understanding of the items that need to be included to determine the appropriate ratios.
Specific comments

The NAIC, through the Accident and Health Working Group of the Life and Health Actuarial Task Force (A&HWG), has done extensive work considering “loss adjustment expenses” and the component parts thereof. The results are detailed in the NAIC’s Statement of Statutory Accounting Principle No. 55 (amended by No. 85) “Unpaid Claims, Losses, and Loss Adjustment Expense.”

For purposes of defining MLR under §2718 of the Public Health Service Act, we believe it is only logical that “loss adjustment expenses” be included in the definition of what constitutes reimbursement for clinical services, just as the NAIC already recognizes. Appropriate adjudication of claims and prompt payment to providers are activities that health plans should not be encouraged to curtail, as would happen if they were classified as administrative expenses for purposes of MLR.

Likewise, “cost containment expenses”, which are currently defined as a subset of “loss adjustment expenses,” should also be included in the definition as reimbursement for clinical services. These functions, including fraud detection and prevention, serve to lower the costs of health care services and ensure that only valid claims are paid. The functions should continue to be encouraged as they serve the goals -- outlined in health care reform -- of containing cost and preventing waste while providing broad health care coverage at a reasonable cost.

PCMA encourages the NAIC to continue to include these expenses on the “loss” side of the MLR. We appreciate the opportunity to comment as you consider these important issues.

Sincerely,

Barbara A. Levy
Vice President and General Counsel
Pharmaceutical Care Management Association

cc: Richard Diamond, Chair, Actuarial MLR Subgroup
    Lou Felice, Chair, Health Reform Solvency Impact Subgroup
    John Engelhart, NAIC Staff
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April 29, 2010

Secretary Kathleen Sebelius
The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

When questioned about health reform during Meet the Press appearances, you stated, “… the market competition is decreasing in this country, that in the individual market, in the small group market where small employers are absolutely caught, they have no choice; and they are getting increasingly frustrated. We have . . . (basic) monopolies in many parts of the country (that) drive the costs up.”

You have consistently—and admirably—argued for improved competition as a key to effective health reform. We couldn’t agree more. And that’s why we believe that changes to medical loss ratios in the individual and small group market must be structured to increase health insurance competition, instead of weakening it.

In 2009, the six largest public insurance companies wrote $35.8 billion in individual and small group major medical. As a point of reference, our company wrote $120 million in these sectors, mainly in rural markets. Obviously, we are small and lack economies of scale, but there are hundreds of companies like us. Combined, we are about 15 percent of the market. Last week, the individual market lost one “A” rated carrier because of health care reform. More will follow unless you take action.

The Need for Smaller Health Insurers

Why should anyone care if the small carriers exit the health insurance market? If they are not efficient, shouldn’t those companies just go away? Although each company is unique, allow me to use our company as an example of the good that is done by small companies.

First, we are innovators. Our typical insurance plan in the individual market for a family costs about $400 a month—roughly 50 percent lower than the national average. We were one of the first to embrace consumer-directed health plans, and continue to give premium discounts to customers based on their active participation in their health savings accounts. We tend to sell outside-the-box plan designs with higher deductibles, sometimes packaged with wellness or accident plans, and tele-medicine or nurse-on-call programs. We offer our customers a wide choice of provider networks and offer plans that do not have out-of-network penalties. Many larger companies have been reluctant to promote consumer-directed health plans because they would experience a significant decrease in premiums, and do not offer plans that can be personalized because they are more expensive to administer.

Second, we deliver a personal customer service experience. Our customers can restructure their plans without penalty when their family dynamics change.

Finally, we have a large presence in rural markets and work with local insurance agents. Anyone who grew up in a small town—like I did—knows that economies of scale and a one-size-fits-all mentality are counter to the very independence and self-reliance of most rural Americans. Small town America likes to do business with small town America. It’s not about being Internet literate; it’s about a way of life. (Health care cooperatives may have a future in rural America, but they will not exist until 2014).
Consideration for Smaller Carriers to Promote Competition

Unless smaller health insurance companies are given consideration in the minimum loss ratio standards, many will withdraw from the small group and individual markets. In fact, companies that rely solely on these product lines will be forced out of business and many jobs will be lost in one of the worst economies in memory. Competition will be reduced even further.

Please allow me to explain. As noted above, the premium for our typical insurance plan is roughly 50 percent lower than the national average, which means that our per-policy expenses are spread over a smaller premium base. In addition, we rely on independent agents to deliver a large percentage of our plans. Since we service underserved rural markets, our costs to write a case are higher than those of a company writing in an urban area. All of these factors cause our administrative costs to be about 5 percent or more higher than the larger insurers. If companies like ours cease to serve these markets, there are few immediate alternatives. The federal high-risk pool was not funded to cover newly uninsured people.

What can be done? About 15 years ago my state of Minnesota created lower loss ratios in the individual and small group market for carriers with less than a 3 percent market share. Other states have lower loss ratios for high-deductible plans because the premium is less. Another possible solution is to allow a portion of the agent commission to be a service fee. At a time with massive changes to insurance plans, the role of an experienced independent agent who provides consultative services should be enhanced not eliminated. (Exchanges may make it easier for individuals to buy plans, but they will not exist until 2014).

But let’s step back from the nuances of how loss ratios can be structured—there are many solutions if you are committed to competition—and focus on the fundamental issue: When too much power is in the hands of too few, innovation is stifled and costs go up. It is basic economics.

Please ask the National Association of Insurance Commissioners to structure the requirements of medical loss ratio so as to promote (not stifle) competition and preserve a place for small carriers and independent agents.

Additional Information About the Author and The IHC Group:

Jeff Smedsrud is senior vice president and chief strategy and marketing officer for Independence Holding Company (NYSE: IHC). The IHC Group includes three insurance carriers, each rated A- (Excellent) by A.M. Best Company, and several administrative and medical management companies. It has approximately $600 million of annual premiums in niche health and life insurance markets in most states.

Smedsrud has been active in health insurance reform since the 1980s. He helped create many of the 35 state programs for the medically uninsured, and was the founder of the National Association of State Comprehensive Health Insurance Plans (NASCHIP—the trade group for state risk pools). In the early 1990s he led a coalition of 16 national agricultural and rural organizations with more than 2 million members that supported principles of health reform. He has testified numerous times before state and federal legislative committees. He also has owned a large health insurance agency that focused on solutions for rural small businesses and the self-employed.
May 3, 2010

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

Re: Medical Loss Ratios

Dear Mr. Felice:

The following comments are sent on behalf of Healthways, Inc. Healthways is the largest and most experienced health, wellness and chronic care management company in the world. Healthways offers comprehensive solutions that improve well-being and decrease healthcare costs.

As you know, the Majority Staff of the Office of Oversight and Investigations, Senate Committee on Commerce, Science, and Transportation, chaired by Senator John Rockefeller (the “Committee”) issued a report on April 15th addressing the implementation of health reform’s new MLR requirement. The report made clear, as did HHS’ April 12th letter, that for the purposes of determining the minimum MLR under PPACA and the Reconciliation Act, health plans “will be able to consider expenditures on ‘activities that improve health care quality’ as medical expenses for the purpose of calculating medical loss ratios.” Although the regulations have not been promulgated and the NAIC is yet to weigh in, the Administration and Congressional Committee staff have provided guidance that the MLR calculation is intended to be derived from a fraction, the numerator of which is total of Medical Claims plus Quality Improvement Costs, and the denominator of which is total Premium Dollars.

The New MLR for Commercial Heath Plans:

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\text{MLR} = \frac{\text{Medical Claims Costs} + \text{Health Improvement Costs}}{\text{Premium Dollars}}
\]

Healthways strongly supports the Administration’s and Committee's approach to capturing invaluable "health improvement activities" under medical claims. Chronic care management programs have been shown to improve adherence to patient’s medical
treatment protocols. Experts believe that this type of improvement resulting from chronic care and disease management programs is essential for making Americans healthier and lowering the current and future economic burden of diseases.\(^1\) Furthermore, studies show that larger employer groups which adopt wellness programs can lower their health care spending. As reported in *Workplace Wellness Programs Generate Savings*, written by Katherine Baicker, David Cutler, and Zirui Song, and published in *Health Affairs*, February, 2010, the researchers demonstrated that medical costs fall about $3.27 for every dollar spent by employers on wellness programs.

Another example of cost-saving health improvement activities is the Healthways’ SilverSneakers® Fitness Program for seniors that has won numerous awards for demonstrated return on investment and positive clinical outcomes with the Medicare Advantage population. SilverSneakers provides physical activity, healthy lifestyle support and socially oriented programming to help seniors take greater control of their health and reduce health claims in the process. According to a 2008 CDC-funded study\(^2\), SilverSneakers participants utilize preventive care more often, are admitted to the hospital less often and have lower overall health care costs. Also, older adults with diabetes who participate in SilverSneakers are also admitted to the hospital less often, have lower inpatient care costs and have significant reductions in their overall health care after only a year of participation, according to a recent study published in *Diabetes Care*, the journal of the American Diabetes Association.

_Taking into account the studies which we have cited,\(^3\) we strongly support categorizing the costs attributable to programs, measures or activities designed to achieve one or more of the following goals as either (1) medical claims costs or (2) health improvement costs that are treated like medical claims/losses:_

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3. Even though these studies were not necessarily related to insured programs, the purpose of citing the studies is to provide evidence that wellness programs do provide measurably positive benefits with regards to medical outcomes.
(A) Wellness, health promotion or fitness;

(B) Disease prevention;

(C) Improvement of health outcomes through disease or chronic care management, patient education, or medication or other care compliance initiatives; or

(D) Patient safety or reduction in medical errors.

We believe that NAIC should conclude that health improvement activities as described above are part of the clinical care which patients receive, are determinative of the medical losses which a health plan ultimately pays or incurs, and must be included in the computation of a health insurer’s medical loss ratio.

Very truly yours,

LOCKE LORD BISSELL & LIDDELL LLP

[Signature]

Norris W. Clark

cc: Todd Sells, NAIC
Vicki Shepard
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