



**BlueCross BlueShield  
Association**

An Association of Independent  
Blue Cross and Blue Shield Plans

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May 17, 2010

Mr. Lou Felice  
Chair, Health Care Reform Solvency Impact Subgroup

By Electronic Mail

**Re: Medical Loss Ratios under Public Health Service Act Section 2718**

Dear Mr. Felice:

The Blue Cross Blue Shield Association (BCBSA), which is comprised of the 39 independent Blue Cross and Blue Shield Plans (“Plans”) that provide health coverage to nearly 100 million Americans, would like to offer our comments as the National Association of Insurance Commissioners (NAIC) works to provide recommendations to the Department of Health and Human Services (HHS) on Section 2718 of the Public Health Service Act, dealing with medical loss ratios (MLRs).

The underlying premise of Section 2718 is very simple – ensuring that at least a minimum percentage of premiums is used to reimburse clinical services and activities that improve health care quality. While this premise appears straightforward, careful consideration of complex accounting and actuarial concepts is necessary to implement this provision in a workable manner that provides useful, consistently-reported information for consumers and regulators.

As the NAIC develops its recommendations on MLR definitions and categories, and particularly regarding the work of the Health Reform Solvency Impact Subgroup (Subgroup) and the proposed Supplemental Health Care Exhibit as released on May 12, we ask that you consider the following two critical recommendations:

**1. Quality Improvement Activities Must Be Encouraged**

As you know, the Patient Protection and Affordable Care Act specifically excludes quality improvement activities from the capped administrative category to ensure appropriate resources for activities that improve health care quality. Some are advocating limiting the types of activities that would be defined as “quality improvement.” If an activity is not included in the quality improvement category, it would be included in the capped administrative category.

If quality improvement activities are not properly classified, health plans will face enormous pressures to cut back on these critical activities in order to fall within the MLR administrative

cap. This is a major concern – especially given all the new mandatory requirements that will add to administrative costs (see attached list).

Important quality improvement programs that should be included are:

- **Provider outreach activities** (e.g., pay for quality, quality measurement and other care coordination and outcome improvements; provider credentialing and network management; provider education designed to improve quality; etc.).
- **Patient safety activities** (e.g., drug interaction and adherence monitoring; programs to eliminate hospital acquired infections; activities to combat abuse; etc.).
- **Member health improvement activities** (e.g., care coordination; case management; consumer education materials; disease management; nurse call lines; wellness programs; etc.).
- **Other quality improvement initiatives** (e.g., accreditation and quality reporting costs required for NCQA and URAC accreditation; clinical research; health IT, etc.).

These activities reflect the six Institute of Medicine “Aims for Improvement” to make care more safe, effective, patient-centered, timely, and efficient. If these activities are not categorized correctly, consumers could lose access to valuable programs that are improving their health and outcomes while reining in costs. (See attached examples of Blue Plan initiatives that would be at risk.)

## **2. Consumers Should Have Meaningful Comparisons Among All Health Plans**

It also is important to recognize the need to provide consumers with the ability to easily compare medical and administrative spending among different health plans, and in particular, between staff and capitated-model HMOs and other insurance models. To accomplish this objective, all health plans should report costs uniformly. Today, group and staff model HMOs report many expenses as “clinical” that other plans include in the “administrative” category. A failure to address this discrepancy would mislead consumers because HMOs would appear to spend a relatively higher percentage on clinical services costs. Consumers should be able to compare plans on an apples-to-apples basis.

In addition, we have some general comments on the overall exhibit as well as technical comments on certain items.

### **General Comments on Overall Exhibit**

We would like to offer two recommendations to help ensure the financial reporting information under consideration by the NAIC is responsive to PPACA’s medical loss ratio (MLR) requirements and provides meaningful, consistently-reported information for consumers and regulators:

1. Focus first on those elements specifically required by federal law, and phase in additional reporting not specified by PPACA at a later time. This would promote timely compliance, consistency with market segment rebating requirements, and achieve accurate and meaningful results for consumers and regulators.

To produce the proposed exhibits that go beyond federal requirements, significant systems upgrades are needed to gather and warehouse the data, algorithms need to be programmed (e.g., to allocate items such as investment income, federal income taxes and other expenses), and processes need to be developed to verify the results. The changes must be made within the new internal controls environment prescribed by the NAIC version of Sarbanes-Oxley (as known as the Annual Financial Reporting Model Regulation), which is vitally important but adds time and cost. These systems changes are needed to ensure the accurate, consistent and comparable information that the new federal requirements are intended to produce for regulators and consumers. A phased approach to such systems implementation would best allow us to accomplish those goals while helping to manage administrative costs associated with these systems upgrades. Based on survey data from the recent Schedule T project, we estimate that these system upgrades could cost in excess of \$1 billion industry-wide.

2. Provide annual rather than quarterly reporting of loss ratio information in order to ensure meaningful information responsive to PPACA requirements. Quarterly reporting may result in misleading data that could cause confusion for regulators and consumers given that it could differ from the annual reporting that will determine the payment of rebates.

Most health insurance products do not have level loss ratios throughout the year due to three main factors including seasonality of claims, seasonality associated with cost sharing (e.g., many plans have calendar year deductibles), and actual claims run-out. Focusing on any single quarter is likely to provide less than full understanding of the health insurers' results.

### **Technical Comments**

Consistent reporting is necessary to provide consumers and regulators with meaningful information. If the MLR reporting under PPACA allows for additional claims run-out time (as is currently the practice with the Medicare Supplement refunds) and if these exhibits need to cross-check to other annual statement exhibits and schedules, then they may not be consistent. To achieve consistency, clear instructions are needed regarding both the due date and the valuation date.

To provide for improved comparability of reported financial results across insurers, we recommend that this exhibit end at Underwriting Gain or Loss. This would prevent arbitrary allocations of investment income, other income, taxes and expenses that are not directly attributable to specific market segments.

Regarding the exhibits' segment columns, we ask that you consider the following:

1. Associations are included within the Individual market segment. Yet in many states, associations are required to follow the Small Group rating laws or are regulated as large group. Furthermore, in many states, current state definitions for the market segments may differ from the federal definitions. It would seem more appropriate to include this business according to how it is rated and regulated.
2. It is unclear whether the definition of Small Group should be the state's current definition or the federal definition, which will require that small groups be defined as 1 to 100 employees by 2016. A definition that differs from the current one adds another layer of complexity to the implementation process.

3. While Medicare Part D stand-alone coverage is not specifically mentioned in the definition of Government Business (column 4), we assume that it would be included.
4. Stop loss coverage is not mentioned in any definition. Should it be included with Other Health, or is it being considered a casualty coverage for this purpose and, therefore, recorded as other business?

Regarding certain line item definitions and calculations, we ask that you consider the following:

#### 1. Premiums

- A. Line 1.5 - The definition of Federal Taxes and Federal Assessments says to include federal income taxes allocated to premium. We assume that the intent is not for income taxes to be allocated by premiums, as allocating by underwriting gain seems more appropriate. At a minimum, we suggest the description for this line be changed to read: "Include all federal taxes and assessments."
- B. It is clear the reinsurance is to be reported, but is not used in the MLR calculation. We suggest that consideration be given to including catastrophic (or excess loss) coverage as it is currently a key risk management tool for many small insurers. With the elimination of both annual and lifetime limits as risk management tools in the near future, even larger insurers may need to purchase catastrophic reinsurance to manage the increased risks.

#### 2. Claims

- A. It is unclear whether to show all prescription drug claims or only those paid under a drug card. Also, pharmaceutical rebates are not usually applied at the market segment and would need to be allocated. The results may not directly relate to the amounts shown for prescription drug claims.
- B. Line 3 defines Incurred Medical Incentive Pools and Bonuses based on arrangements that "share savings." Insurers also incent providers for quality. We suggest that the definition be modified to read, "share savings or promote quality."
- C. If catastrophic reinsurance is allowed in the MLR calculation, then appropriate offsets need to be included in the claims.
- D. Line 4.3 is for reporting of rebates paid that would be subtracted from incurred claims. It is unclear to us that any rebates would be paid out as claims or as a refund of premium. Further statutory accounting guidance is needed. If rebates are paid as a refund of premium, then the premiums reported in the Statement of Revenue and Expenses would be reduced to reflect the incurred rebates. For the MLR rebate calculation, the earned premiums should exclude the issuer's incurred rebates for the period (i.e., add them back in) as the starting point. In 2014, when the rebate formula uses a three-year average, any prior year rebates need to be shown as incurred claims instead of premium reductions to enable the MLR for those prior years to be shown properly.
- E. Lines 2.6 and 2.7 of Part 2 refer to contract reserves. More guidance is needed regarding which types of contract reserves and under what circumstances are they to be included or excluded. Also, these reserves are generally established to reflect shortfalls in future premiums rather than as adjustments to claims.

3. Claims adjustment expense ratio

Line 8 is a calculation of the claims adjustment expense ratio. Since some of the expenses that are currently within statutory definition of claims adjustment expense are included in the MLR, this ratio does not seem meaningful. As an alternative, this line could be incurred claims plus claims adjustment expense ratio, which relates to the reporting of the Underwriting & Investment Exhibit Part 2C.

4. Sales and administrative expenses

It is unclear how the defined expense lines should coordinate with how expenses are reported within the annual statement.

5. Administering self-insured business

PPACA does not require reporting of self-funded business. In addition, Statement of Statutory Accounting Principle (SSAP) 47 clearly states that self-funded business is not to be directly reported, but only as offsets to the associated expenses.

6. Net investment income

Invested assets are not usually segmented by market. Any allocation of net investment income to the various market segments would be arbitrary and, therefore, not meaningful.

7. Other indicators

Line 3 Number of Plans is defined as the total number of insurance plans issued as of the end of the reporting period. In order to be consistent with current financial reporting terminology, we suggest changing this to Number of Policies defined as the total number of policies in force as of the end of the reporting period.

\* \* \*

Thank you for the opportunity to comment on PHSA Section 2718. We look forward to continuing to work with you on this issue.

Sincerely,

Joan Gardner  
Executive Director, State Services

cc: Steve Ostlund, Chair, PPACA Actuarial Subgroup  
Todd Sells, NAIC Staff  
Brian Webb, NAIC Staff  
John Engelhardt, NAIC Staff  
Barb Lane, NAIC Staff

Attachments

## Attachment 1

### Near-Term PPACA Provisions that Add Administrative Costs

There are a number of provisions in the health care reform law that will add to insurers' administrative costs in the near-term (before 2014). The following are some examples:

- **Extensive reporting requirements for the new HHS insurance web portal.** Initial submission due by May 21, 2010. Reporting includes corporate and contact information, administrative information (such as enrollment codes), enrollment data by product, product names and types, whether enrollment is currently open for each product, geographic availability information (such as product availability by zip code or county), customer service phone numbers, website links, brochure documents (such as benefit summaries and provider networks) and financial ratings. Additional categories of information will be required by September 3, 2010, and again in 2011.
- **New “coverage transparency” reporting** to HHS and state insurance commissioners concerning claims payment policies/practices, financial disclosures, enrollment/disenrollment data, claims denials, rating practices, cost-sharing, payments for non-network coverage and enrollee rights information.
- **New annual quality reporting** to HHS and enrollees on insurer activities to improve health outcomes, prevent hospital readmissions, improve patient safety, reduce medical errors, and implement wellness and prevention programs.
- **New administrative simplification requirements** including adoption of CAQH CORE operating rules and implementation of the unique health plan identifier that will require major systems changes.
- **Immediate benefit and coverage changes** that require major claims, enrollment, and other systems and operational changes, including:
  - Coverage for preventive services with no cost-sharing
  - Dependent coverage to age 26
  - No pre-existing condition exclusions for children under age 19
  - Prohibition of lifetime limits
  - Restrictions on annual limits
  - External review requirements
- **Monitoring “grandfathered” status** across various products at the member and account level.
- **Detailed, uniform coverage summaries** for consumers meeting new HHS standards.
- **New “cost sharing transparency” reporting** to individuals, upon their request, of the cost sharing for specific items or services provided by participating providers.
- **Rate review requirements** with justifications for “unreasonable” rate increases.
- **MLR reporting and rebate requirements** following HHS guidelines and methodologies.

## **Attachment 2 - Examples of Blue Plan Initiatives to Improve Quality**

**Eliminating Hospital Acquired Infections:** Plans are working with hospitals to provide tools to eliminate hospital acquired infections (HAIs). Plans underwrite most of the costs for hospitals to acquire needed technology to reduce HAIs. One statewide initiative has estimated to have saved 209 lives and \$27 million in 2009 by preventing 2,233 HAIs and avoiding 12,819 hospital days.

**Reducing Hospital Readmissions:** Many Plans have initiatives in this area. One Plan launched a disease management program in 2001 designed to reduce hospital admissions and improve medication compliance for members with congestive heart failure (CHF). The program used educational materials and one-on-one physician coaching and outreach to improve self-management techniques, as well as offered biometric monitoring equipment to high-risk CHF members that allowed them to report on their conditions from home. The coordinated efforts led to a five percent reduction in hospital readmission rates among members with CHF.

**Coordinating Care and Managing Disease:** Plans are using critical health IT tools while also offering primary care physicians financial incentives to provide comprehensive, coordinated patient care and management of chronic diseases. Pertinent claims data is shared with providers that can tell the physician which of his or her patients have diabetes and which have not had important tests or screenings as part of their recommended care, such as a blood glucose test within the last year. With this information now readily available, physicians are able to reach out to the patient to make sure they are getting the care they need. This program is yielding impressive results: for one plan in just one year, compliance rates for HbA1c blood tests (a key health status indicator for patients with diabetes) jumped from 40 percent to over 90 percent.

**Encouraging Employee Wellness:** A Plan has a comprehensive employee wellness program that was the subject of a comprehensive return-on-investment review published in the February 2008 issue of the *Journal of Occupational and Environmental Medicine*. The study found that every dollar invested by the Plan to operate a worksite wellness program resulted in \$1.65 in cost savings from avoided health care expenses among participating workers, totaling more than \$1.3 million in savings over a four-year period when compared to a control group. The study demonstrated the value of worksite wellness programs, reinforcing the benefits to employers and employees in terms of improving overall health and generating financial savings.

**Preventing Adverse Drug Events and Lowering Drug Co-Pays:** A Plan is promoting e-prescribing adoption by subsidizing physicians' adoption costs and incentivizing providers to obtain and use the technology. Approximately 724 adverse drug events have been prevented, resulting in savings of \$630,000 from hospitalizations that were prevented. In addition, consumers have saved approximately \$800,000 in co-payments on their prescriptions.

**Improving Patient Safety by Combating Fraud and Abuse:** Blue Cross and Blue Shield Plans are committed to doing our part to eliminate healthcare fraud. The 39 Blue companies and our 600 anti-fraud experts teamed with law enforcement to save our 100 million customers nearly \$350 million in savings and recoveries in 2008 and potentially reduced inappropriate and sometimes harmful care.