

To: Steve Ostlund  
Richard Diamond  
Julia Philips  
Gloria Dee  
Lou Felice

Fr: Timothy Jost  
Wendell Potter  
Stephen Finan  
Georgia Maheras  
Kim Calder  
Bonnie Burns  
Barbar Yondorf  
Joe Ditré  
Brendan Bridgeland  
NAIC consumer representatives

Re: NAIC Working Group Blanks Proposal

We are writing to express our general support for the Blanks proposal currently being considered by the NAIC PPACA Actuarial Subgroup for implementing PPACA section 2718. We appreciate the fact that the Subgroup has taken seriously the MLR principles and recommendations submitted by the NAIC consumer representatives, which we see reflected in the Blanks proposal. We understand that you are under a great deal of pressure to change your proposal in various directions, and urge you to continue to prioritize the interests of consumers, which we believe to be the ultimate concern of Congress in enacting PPACA, as you proceed with implementation.

We have a few comments that we urge you to consider as you continue to move forward with the Blanks proposal.

p. 5. While we understand that section 2718 does not apply to limited benefit plans, we urge you to take care that “mini-med” plans that are not specifically exempt by statute or regulation are not allowed to avoid the minimum loss ratio requirements imposed on comprehensive plans.

pp. 8 – 9, lines 2-1 to 2-3. We join with BCBSA and the FAH in urging you to make certain that staff and capitated HMO plans, as well as insured plans that contract out coverage (like behavioral health coverage) to managed care entities, compete on a level playing field with insurers that pay for services directly. Limiting incurred claims to actual payments to providers would seem to accomplish this. We support this approach.

Line 2-3 only acknowledges rebates from pharmaceutical companies. Other providers, such as medical device manufacturers, also provide rebates, should they not also be listed here?

p.9, line 3. It would seem that shared savings programs should not automatically be credited as claims incurred. If the purpose of an incentive program is to improve quality, its cost should be acknowledged. If the purpose of a shared savings program is to reduce the quantity of services provided, perhaps the question needs to be asked if the program is improving or impeding quality.

p. 10, lines 5-1 and 5-2. We applaud the general approach that the working group is taking to the definition of quality. Consumers benefit from programs that actually improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered care. Congress included the cost of these programs, therefore, in the numerator in the 2718(b) formula for determining rebates. It is important, however, that the definition of quality not be expanded to include all activities that insurers carry out that improve the quality of the insurance product, including fraud prevention and cost control. Although these activities may ultimately benefit insurance consumers, they are not the quality promotion activities that Congress intended to include in the numerator. The Blanks proposal basically draws the line at the right place between activities that promote quality of medical care and those that control costs or achieve other insurer goals.

The preface to 5.1 refers to activities that are “designed to” improve quality “in ways that can be objectively measured and verified.” We would urge you to go further and insist that the activities in fact be evidence-based; that insurers be required to provide evidence that the activities are in fact promoting quality of care.

We support the requirement that quality activities be “hands-on” and not just general public service programs. “Hands-on” activities should involve personal, telephonic, or email communications with individual patients.

It is important to distinguish between HIT activities that actually improve quality and those that serve other functions. We support the proposal’s attempt to do this.

Line 7.2. Although loss adjustment activities must be reported under the ratio identified in 2718(a), they are not part of the numerator for the 2718(b) rebate formula. We support the proposal’s recognition of this fact.

In addition to the Blanks proposal, we have also reviewed Steve Ostlund’s memo of May 14. We realize that the issue of credibility is a difficult one that must be addressed. We are troubled, however, by the notion that members of a noncredible pool would never be able to receive a rebate. We would urge continued consideration of this issue along the lines that Mr. Ostlund suggests.

More broadly, although the statute recognizes that special consideration should be given to smaller plans, different types of plans, and newer plans, it may also be the case that certain types of plans that will never be able to achieve MLRs approaching the levels set by the statute should simply not exist. Do we really need insurance plans that will consistently return less than 80% of their premiums to their enrollees in benefits, year

after year? If such plans do continue to exist, they should at least be required to disclose to their enrollees and to the public the fact that they will not conform to the 2718 MLR requirements, and this fact should be clear and not obscured by special reporting requirements.