



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

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May 24, 2010

Mr. Lou Felice
Chair, NAIC Health Reform Solvency Impact (E) 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 (PHSA), dealing with medical loss ratios (MLRs). We appreciate the opportunity to provide additional comment as the NAIC’s Health Reform Solvency Impact (E) Subgroup continues its work on the Supplemental Health Care Exhibit discussion draft.

1. Health Quality Improvements

We commend the NAIC for seeking to align “Expenses for Health Care Quality Improvements” with activities that Congress considers essential for quality improvement, recognizing that Congress identified a broad range of essential quality improvement activities in Section 2717 of PHSA. The NAIC might also wish to note that in Section 1311, Congress specifies these activities (plus activities to reduce health care disparities) as the essential components of a “quality improvement strategy” for Qualified Health Plans, and Congress also requires that Qualified Health Plans be accredited, a process that itself requires an abundance of quality-improving activities.

Since a health insurance issuer that is a Qualified Health Plan must develop, implement, and report to the Exchange on the broad quality improvement categories specified in Section 1311 – and also carry out all of the accreditation activities listed in Section 1311(c)(1)(D)(i) that increase the likelihood of desired health outcomes – it is

important that the MLR / Quality Improvement definition be consistent with what Congress defined as the essential components of a quality improvement strategy.

To ensure consistency, it is important that the categories included as quality of care expenses, for the purposes of reporting in this supplemental filing and calculating the medical loss ratio, are inclusive of the activities specified by Congress in Sections 2717 and 1311. Therefore, we urge the NAIC to:

- Amend the existing categories to embed the quality improvement activities called for by Congress in sections 2717 and 1311.
- Clarify that quality improvement activities involve both health services for individuals (such as one Plan's integrated care cancer medical management program that uses skilled care management nurses, decision support tools and community participation to improve the health and quality of individuals with cancer) and health services for populations (such as the programs noted below to eliminate HAIs).

It is especially important that the MLR give full consideration to efforts to reduce healthcare acquired infections (HAIs), which the Agency for Healthcare Research and Quality (AHRQ) identified in its recent *2009 National Health Care Quality Report* as one of the most serious patient safety concerns: "In hospitals, safety remains a significant problem... and healthcare associated infection rates are not declining."

A number of Plans have funded programs to eliminate healthcare-associated infections by implementing HAI monitoring systems and best practices. For example, one Plan partnered with 62 hospitals in a statewide collaborative that saved 209 lives in 2009 by preventing 2,233 HAIs and avoiding 12,819 hospital days.

- Expand the scope of Health IT expenses to ensure that health insurance issuers are able to carry out such quality improving activities as developing and giving members Personal Health Records to help them live healthier lives and manage chronic conditions; helping providers buy or use health IT to improve patient care; or investing in new information systems to measure, analyze, and report quality outcomes to providers and to members.

For example, some Plans have helped subsidize physicians' adoption of certified Electronic Health Records (EHRs) and helped them obtain and use technology to improve care.

- Add a category for "Quality Reporting" that includes activities at the "front-end," such as collecting data from providers through manual chart reviews, and at the "back-end," such as analyzing those data for quality assurance purposes, giving constructive feedback to providers, and giving support to Maintenance of Certification programs that assure physician competency.

For example, one Plan has implemented a program that monitors and measures the

practice patterns of health care providers, assesses those data for variance in practice patterns, and then initiates outreach to providers to ensure that members receive evidence-based care. This program led to practice changes that have resulted in improvements in the quality of care.

We agree, as set forth in Line 5 of the Supplemental Exhibit instructions, that health care quality improvement activities should be designed in ways that can be objectively measured and verified. However, we would caution against requiring measurement and verification on a prospective basis because this would have a chilling effect on innovation, and hinder creative approaches to improving health care quality.

Indeed, the MLR process as a whole should ensure that industry has the needed flexibility to innovate quickly, to design unique programs tailored to their particular markets around health disparities, to discard methods that do not work, and swiftly carry out methods with promise. Therefore, we urge the NAIC not to create hurdles to innovation and swift implementation by adding additional layers of review that need prospective, empirical evidence on performance. Requiring that quality improvement programs must be designed in ways that can be objectively measured and verified will ensure both innovation – the ability to test new approaches or to apply older methods in new settings – and responsibility – since health plans, as fiduciaries for their members' scarce premium dollars, are unlikely to maintain programs designed to improve quality if measurement and verification show that those programs do not improve quality.

We also would recommend that in creating standards for the MLR, the NAIC give full consideration to maintaining a level playing field among different health plan models. If any particular activity is ultimately excluded as an expense for health care quality improvement, then uniformly it should not be counted as a medical expense, including for group and network model HMOs that may currently report certain quality-improving activities (such as disease and case management and health risk assessments) as medical expenses. This uniform treatment would create a level playing field. Only with such a level playing field would consumers be able to make informed, apples-to-apples comparisons among their health care choices.

Finally, we would note that if the NAIC does not classify quality improvement activities consistent with the intent of Congress as expressed through sections 2717 and 1311 of PPACA, then health plans will face enormous pressures to cut back on these critical activities in order to live 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 of near-term examples). Therefore, we hope that the NAIC will add weight to its objective of aligning the MLR with quality improvement activities supported by Congress.

Additional Comments

As noted above, it is important that consumers have meaningful comparisons among all

health plans, including 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, staff and capitated model HMOs report many expenses as “clinical” that other plans include in the “administrative” category (see attached list from the Sherlock Company, a financial consulting firm). A failure to address this discrepancy would mislead consumers because certain 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.

To help ensure the financial reporting under consideration by the NAIC is responsive to PPACA’s MLR requirements and provides meaningful, consistently-reported information for consumers and regulators, we recommend the following:

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.

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.

3. Line 1.5 - The definition of Federal Taxes and Federal Assessments reads to

exclude federal income taxes on investment income and capital gains. As we understand it, the rationale for the exclusion is based on the assumption that investment income does not relate to the insurance operations of an insurer. However, insurers are statutorily required to hold reserves and capital to sustain the insurance operations. Investment income is generated from the assets supporting these reserves and capital, and not as a separate line of business. We recommend that the exclusion be deleted from the instructions.

4. Line 1.8 is for the reporting of Regulatory Authority Licenses and Fees. The definition specifies the exclusion of fees for examinations by state departments. These examinations, which are in addition to annual external auditor reviews, are required under state insurance laws. They are performed by state regulators, or their subcontractors, with the fees charged directly to the insurer even though the insurer has no control over the amount of the fees. We believe that statutory examination fees meet the definition of regulatory fees, and, therefore, should be included in the definition.
5. We recommend including adjustments for 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.
6. Line 3 – Clarify that the arrangements that promote quality Improvements are those set out in federal law.
7. Lines 4.3 - 4.5 are for reporting of incurred rebates to be subtracted from incurred claims. We believe that it is more appropriate to pay any rebates out of premium accounts than claim accounts, as payments to policyholder do not seem to meet the definition of benefits under a policy. Our suggested treatment would also be consistent with the current accounting treatment of experience-rated refund contracts. 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. However, 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.

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Thank you for the opportunity to comment on the NAIC's Supplemental Health Care Exhibit discussion draft. 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

SHERLOCK

C O M P A N Y

To: Alissa Fox
Senior Vice President
Office of Policy and Representation
Blue Cross and Blue Shield Association

From: Douglas B. Sherlock, CFA
President

Re: Quality Expenses Delegated in Capitation

Date: May 13, 2010

I understand the Department of Health and Human Services (HHS) and the National Association of Insurance Commissioners (NAIC) are working to develop a definition of “activities that improve health care quality” that would be excluded from the administrative cost category in calculating health plan MLRs.

It is important to note that many of the activities are already reported by group and network model plans in the clinical category of the MLR. Reporting of these activities varies by plan and also by the contractual relationship between the plan and its providers.

Examples of activities related to quality that group and network model HMOs may report as medical expenses today are:

- Care coordination
- Case management (i.e., more patient-specific intervention than care coordination)
- Disease management programs
- Network access fees
- Network development costs
- Nurse call lines
- Costs related to quality measurement/reporting in pay for performance programs
- Provider credentialing (e.g., ensuring appropriate licensure)
- Provider education designed to improve quality
- Certain administrative costs associated with processing claims (including time edits to enforce preventive guidelines, drug abuse quantity limits, bundling rules, etc.)
- Detection and prevention of payment for fraudulent requests for reimbursement
- Health IT initiatives
- Certain investments in claims and other payment systems (e.g., identifying treatment patterns that warrant medical quality review)
- Patient monitoring programs
- Health risk assessments

In addition to the items listed above, it is important to note that there are other responsibilities that can be assumed by capitated providers to group and network model HMOs that have the effect of reporting those expenses as health benefits. These include certain customer service activities, the internal payment systems of medical groups (including those similar to claims systems) and information systems costs that support these activities.

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). Following are some examples:

- **Detailed, uniform coverage summaries** for consumers that meet new HHS standards.
- **Notice of mid-year changes** to any modification not included in most recent summary, per above.
- **New “coverage transparency” reporting** to HHS and state insurance commissioner that is made public on claims payment policies/practices, financial disclosures, enrollment/disenrollment data, claims denial and rating practices, cost-sharing and payments for non-network coverage and enrollee rights information.
- **New “cost sharing transparency” reporting** to individuals upon their request of the cost-sharing for specific items or services by a participating provider.
- **New annual quality reporting** to HHS and enrollees of plan activities to improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, and implement wellness and prevention programs.
- **MLR reporting and rebate requirements** following HHS guidelines and methodologies.
- **Immediate insurance reforms** that require major systems and operational changes, including:
 - Out-of-network emergency care
 - Dependent coverage to age 26
 - No pre-existing condition exclusions for children under age 19
 - Consumer choice and access to certain providers (e.g. PCPs)
 - Internal appeals
 - External review requirements
 - No discrimination in coverage or premium based on salary
 - Prohibition of lifetime limits
 - Restrictions on annual limits
 - Coverage for preventive services with no cost-sharing
- **Rate review requirements** with plan justification for “unreasonable” rate increases.
- **Reporting requirements for the new HHS insurance web portal** including insurer-specific information for publication.
- **Maintaining dual systems to account for “grandfathered”** and non-grandfathered plans.
- **New administrative simplification requirements** including adoption of CAQH CORE operating rules and implementation of the unique health plan identifier.