

The Council for Affordable Health Insurance



May 7, 2010

Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup, NAIC
New York State Department of Insurance
25 Beaver Street
New York City, NY 10004

Dear Mr. Felice:

I write on behalf of the Council for Affordable Health Insurance (CAHI) to offer comments to assist the NAIC in its very important advisory roll on the joint request for information published by the Department of Health and Human Services, the Department of Treasury and the Department of Labor in the Federal Register on April 14. CAHI offers comments below on what we believe are some critical definitional aspects of the minimum medical loss ratio (MLR) calculations for individual and group coverages.

The Council for Affordable Health Insurance (CAHI) is a national research and advocacy organization devoted to market-based health care reforms that preserve freedom of choice for individuals and encourage a competitive health insurance market. CAHI members include health insurers, physicians, actuaries, agents and small business owners. Our member companies are active in the Medicare supplemental (“Medicare Supplement”), individual, small group, health savings account and senior markets.

Cost Containment as an Important Aspect of Medical Costs

We have serious concerns with the notion that cost containment expenses can reasonably be excluded from medical costs. One of the fundamental reasons to require plans to meet a loss ratio is to ensure that patients receive the highest possible value for their health care dollar. Excluding many cost containment tools from the consideration of either medical claims costs or activities that “improve health care quality” under the new reform law will only harm patients, while removing an important incentive for carriers to spend consumer dollars on health claims in a consistently wise and prudent manner.

For example, several state insurance laws recognize the costs associated with the creation and maintenance of provider networks as a legitimate portion of medical expenses, and not an element of administrative costs. Provider networks have been proven to reduce expenses for both carriers *and* their customers. More to the point, they offer quality control elements at the clinical level that are otherwise unattainable. For example, in order to qualify for in-network status, providers must complete a rigorous credentialing process ensuring quality care for all network patients.

Other cost containment services – like precertification – help to ensure that patients are receiving medically appropriate, high quality care. These services also save the patient significant out-of-pocket costs. Excluding these activities from medical care is likely, over the long run, to lead to higher medical and insurance costs.

But perhaps the biggest problem with allocating these activities as administrative expenses for purposes of calculating the new minimum MLR requirements is that it creates precisely the wrong incentive. This is because insurers who act appropriately will be both lowering their medical loss ratios *and* increasing their administrative expenses. This “double hit” could well discourage carriers from effectively controlling medical claims costs, while improving the quality of care received in exchange for those payments.

Therefore, we respectfully ask that you carefully consider retaining some or even all reasonable cost containment related activities – and the costs associated with them – within the purview of medical expenses or improvements in the quality of care.

Improving Patient Care

Given the pace of medical innovation, it is highly likely that the delivery of patient care will change (and hopefully, improve) greatly in the coming years. The pending loss ratio definition is one of the earliest and most important decisions that will be made as part of the federal rulemaking process. We would therefore suggest that the NAIC consider a broad definition of what should be included in medical expenses. This flexibility will help to ensure that patients have a variety of delivery options in the marketplace – from tightly managed HMOs to true indemnity insurers.

Insurers also engage in significant medical management activities, the costs of which may inadvertently be categorized as “administrative.” But they are fundamentally directed at the quality and overall value of the care provided:

- Medical management can prove especially valuable to patients in finding medical providers, and working with patients to evaluate their treatment options;
- Nurse “healthlines” provide patients direct access to qualified nurses and other clinical professionals, and should properly be considered as an integral part of patient care;
- Network credentialing ensures patients are treated by quality medical providers;
- Network-related costs ensure patients have access to a choice of high quality medical providers;
- Collection of HEDIS and other patient quality data ensures patients are receiving high quality care; and
- Transplant network access and contracts with centers of excellence offer significant patient benefits. Many local hospitals rarely, if ever, perform many of the procedures offered through these arrangements, which can offer better clinical outcomes and fewer complications.

Loss Ratios and Their Potential Adverse Impact on Bronze and Silver Plans

We are concerned that the medical loss ratio standards could have an adverse impact on the availability and affordability of plans with lower actuarial value – especially plans that are now actuarially comparable to or will become “bronze” or “silver” plans as those standardized benefit options are brought into the market. The MLR standards would penalize these plans relative to plans with higher actuarial values. This is due to the fact that these benefit plans are often not designed to pay first-dollar claims for routine expenses. As a result, they would not be able to include these claims in the numerator

as “paid claims.” The issue is that such plans must still *process* these claims to apply network discounts, member cost-sharing, and appropriate accounting against deductibles and out-of-pocket limits. As a result, the administrative costs associated with these processed but not paid (by the plan) claims are higher as a percentage of premiums collected. This requirement will almost certainly incentivize insurers to offer more expensive plans that allow for higher administrative expenses, while discouraging the marketing of more modestly priced silver and bronze plans. The likely result is a future market dominated by more expensive “gold” and “platinum” plans, adding significantly to the costs of public income-based subsidies provided under the new reform law.

The simple reality is that a number of the administrative costs associated with insurance are relatively fixed. If we assume two individuals with the same claims history, one who purchases a high value plan and one who purchases a lower value plan, the MLR requirements create a perverse incentive which hurts the lower value, lower cost plan. This is because both individuals have the same number of claims, and it costs the same to process each of those claims. It costs the same to provide access to 24 hour, seven-day-a-week customer service on a toll free line. It costs the same to collect the premiums. The fact is that most insurance company costs are relatively fixed.

We would urge the NAIC to incorporate this concern into their input to the federal agencies.

MLRs and Individual Plans

We have serious concerns with the impact of the proposed minimum MLRs on perhaps the most vulnerable and cost conscious segment of the market -- individual health insurance plans. We believe a temporary exemption from these standards is appropriate – at least until the insurance exchanges are fully implemented under the new reform law. This is necessary due to the higher marketing, premium collection, and other expenses associated with most individual insurance plans.

The NAIC standards for individual market loss ratios vary between 55%-65%, depending on the type of plan. In fact, most guaranteed renewable plan loss ratios are set by the states at 60% or less. Even California – a state heavily dominated by managed care and non-profit insurance plans – sets its loss ratio at 70%. Without some relief from the proposed MLR requirements – either by incorporating the benefits of cost containment activities as part of either medical- or quality-related expenses (see above), or a temporary safe harbor for individual market plans – we fear there will ultimately be little room for meaningful competition in all the states, not just the states cited by President Obama in his speech before Congress.

Small Company Issues

We agree with those, including the U.S. Health and Human Services Secretary, who have expressed concerns about preserving the ongoing viability of smaller carriers in the health care marketplace. These companies face unique market and regulatory challenges that should be taken into consideration in the proposed minimum MLR calculations. We would specifically ask you to keep in mind the following:

- Smaller insurers should be exempted from the tighter MLR rules;
- Smaller companies should be given more flexibility in MLR calculations between blocks of business, and in combining blocks of business for MLR purposes; and
- Reinsurance expenses should be considered as a medical expense and not an administrative expense.

It is important to note that health reform implementation will be particularly costly for many of these smaller companies. At least during the implementation period through 2014, the MLR standards should reflect the heavier financial burden borne by small companies and we would urge policymakers to adopt some reasonable accommodations to provide meaningful relief to this important segment of the market.

Combining Insurance Blocks

One of the major issues for the federal government going forward is whether or not the individual and small group markets should be combined for the purposes of calculating the minimum MLR standards. We would urge the NAIC to recommend to the federal agencies that carriers be afforded the flexibility to make that determination on a carrier-by-carrier basis.

We greatly appreciate the opportunity to provide input on an issue of significant importance to our members. Please do not hesitate to contact me if you have questions.

Sincerely,



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