

July 6, 2010

Commissioner Alfred W. Gross, Chair, Financial Condition (E) Committee
Mr. Lou Felice, Chair, Health Reform Solvency Impact (E) Subgroup
Members of the E Committee

RE: NAIC Life and Accident & Health Blank, Supplemental Health Care Exhibit

VIA ELECTRONIC MAIL

Dear Commissioner Gross, Mr. Felice, and Commissioners:

Your Consumer Representatives to the NAIC, representing millions of patients, consumers and workers, are writing to comment on the Supplemental Health Care Exhibit drafted by the Health Reform Solvency Impact (E) Subgroup to implement the requirements of 2718 of the Accountable Care Act. In accordance with the instruction given by Mr. Felice on the July 1 conference call of the Subgroup, we are limiting our comments largely to the issues left open following that conference call. We have filed numerous detailed comments earlier on many other issues raised by the blanks process. We assume that you have access to these, but would be pleased to provide you with copies if you do not have them.

We have greatly appreciated the leadership provided by Mr. Felice and by the Subgroup in what has been a long, complicated, and controversial process. We as consumer representatives have spent many hours on conference calls over the past weeks and many more hours drafting, circulating, and reviewing comments to be submitted regarding issues raised on these calls. The Subgroup has resolved many contentious and difficult issues over these weeks. The process has consistently been inclusive, participatory, thoughtful, and scrupulously attentive to the intent of Congress in drafting 2718. Mr. Felice and the Subgroup members have been unfailing patient and gracious in helping all participants, including consumer representatives, to understand the positions the Subgroup has taken. They have also been fair and impartial in considering the concerns of all parties involved in the process. We believe that the result they have reached is on the whole reasonable, and implore the NAIC to hold to these decisions.

As we reach the end of the blanks drafting process, it may be useful to return to basic principles. Section 2718 does not say that insurers are entitled to 15 or 20 percent of premiums for their administrative expenses, to which will be added the cost of anything they do that is of value to their enrollees or that pursues a valid health policy goal, including goals endorsed by the Accountable Care Act. Rather section 2718 says that insurance enrollees are entitled to have 80 or 85 percent of their premiums spent on clinical health care services, and that the cost of activities that improve health care quality can be counted against that 80 or 85 percent. There are many things that insurers do that are very worthwhile—valuable to their enrollees and to society. Fighting fraud, controlling costs, discouraging excessive utilization, making certain that providers are qualified, seeking accreditation, coding using ICD-10, and improving public health—

these are all valid activities. Indeed, they are all activities that are endorsed at various places in the Accountable Care Act. But these are not activities that section 2718 says can be paid for out of the 80 or 85 percent of premiums allocated to clinical services.

Insurers argued over and over again in these proceedings that these activities should be paid for out of the 80 or 85 percent to which consumers are entitled for clinical services and quality improvement costs. At points they even seemed to say that if they had to pay for these activities out of their 15 or 20 percent they would stop doing them. Many of these activities are legally required, others are demanded by employers, others are simply best practices—the mark of a quality health insurance product. But they are not activities that fit within the definition of 2718 or within its purpose, which is to bring down the cost of health care coverage and ensure that consumers receive value for their premium payments. We oppose changes that would allow their cost to be counted against the MLR.

We now address the issues specifically left open by Mr. Felice:

- First, the Subgroup is recommending that expenses incurred by issuers to detect and recover payments attributable to fraud be excluded from administrative costs for the MLR calculation to the extent that they actually result in fraud recoveries. Although it seems reasonable to not penalize insurers for fighting fraud by adding their fraud recovery expenses to their administrative costs while subtracting their recoveries from their claims expenses, nowhere does 2718 grant the NAIC discretion to take this approach. We prefer this approach, however, to an approach that would allow issuers to claim their fraud prevention and detection expenses as quality improvement expenses, a resolution some insurers have urged but which would be wholly contrary to the language of the statute and the intent of Congress. We are concerned, however, that insurers not be allowed to claim any money spent on utilization review or claims audits that result in recoveries of overpayments as fraud detection and recovery expenses. Mr. Felice assured us that this would not happen, but we believe that clear definitions are needed to assure that it does not.
- We continue to object to including “transparency” as part of the definition of quality. We strongly endorse transparency. While many of the provisions of the ACA, require disclosure of information, including health-data, quality-related information,” by insurers, we do not believe that the cost of compiling and disclosing this information should be included as a quality expense. The cost of using health care data to improve transparency is not a quality improvement activity. Nowhere in sections 2717 or 1311 is it identified as such.
- We endorse the Subgroup’s decision to exclude the mention of section 3011 from the quality definition. Section 3011 deals not with insurer quality improvement activities but rather with a much broader national quality strategy, including public health concerns and issues of transparency and efficiency. The subgroup properly focused on sections 2717 and 1311, the ACA sections dealing with insurer quality improvement efforts.

- We strongly endorse the Subgroup’s decision to not include the costs of the ICD-10 conversion as a quality expense. Insurers are changing from ICD-9 to ICD-10 as part of a worldwide change in coding standards, one mandated of providers by CMS. ICD-10 coding may make it easier to track quality activities, but it is fatuous to contend that the change is itself a quality of care activity. Had the ACA never been adopted or not included section 2718, insurers would still be adopting ICD-10.
- We strongly support the continued identification of concurrent and retrospective utilization review, provider contracting, and network management costs as cost control and not quality improvement activities. No doubt these activities have some effect on quality. But they are fundamentally administrative activities and should remain classified as such. Insofar as these activities can be identified as case management, disease management, care coordination, or discharge planning activities related to quality they are already covered under the blank.
- We are uncomfortable with prospective utilization review being listed as a potential QI activity without an explicit recognition that some prospective utilization review activities are not QI. We understand that this is implicit, but prefer it being explicitly stated.
- We support the committee’s current approach to handling the addition of new proposals for quality of care expenses, which would require explicit proposals being approved by the NAIC and certified by HHS. Earlier proposals that would have permitted the addition of new categories without an explicit review process would be unworkable and open to serious abuse.
- We support the Subgroup’s recommendation that taxes on investment income not be subtracted from the denominator. Investment income, which for some insurers is a major source of revenue, is nowhere considered in the MLR formula, which only considers premium income. It would be grossly unfair to allow insurers to subtract these taxes from their premium income while not having to account for the investment income on which these taxes are based. We realize that 2718 does not explicitly give the NAIC authority to exclude these taxes, but neither does 2718 explicitly authorize many of the other decisions the NAIC is considering, including the Subgroup’s proposal for dealing with fraud and abuse recoveries. To the extent that 2718 gives the NAIC discretion to establish definitions and methodologies to deal with issues not expressly addressed by 2718, it allows it to prohibit insurers from claiming credit for taxes on income that they are not required to list as income. If the NAIC lacks this discretion, much of the rest of the blank will need to be thrown out as well.
- We are cognizant of the difficult issues raised by community benefit expenditures of nonprofit and tax exempt organizations. However the NAIC chooses to resolve this issue, it must remember that these expenses are neither claims for clinical services nor quality improvement expenses, so they must in some way be tied to the exclusion of taxes. They must, therefore, be linked to premium taxes, income taxes, or some other form of tax and limited accordingly. Again, the NAIC does not have unbridled discretion to allow insurers to claim any of the useful things they do in the MLRs.

- While recognizing that accreditation plays an important role in improving health insurance products and quality of care, we oppose allowing accreditation fees to be counted as quality of care expenses. The National Committee for Quality Assurance (NCQA) accreditation is based on six categories of accreditation standards:
 - Quality management and improvement,
 - Utilization management,
 - Credentialing and recredentialing,
 - Members' Rights and Responsibilities,
 - Standards for Members Connections, and
 - HEDIS/CAHPS performance measures

While most (but not all) quality management and improvement and HEDIS/CAHPS standards address quality of care improvement, the remaining standards do not. All of the issues accreditation addresses are important to consumers, but not all are related to improving health care.

The NCQA website states "Health plan operate in a highly competitive environment, often vying for business with local, regional and national firms. NCQA Accreditation helps health plans demonstrate their commitment to quality and accountability and provides extraordinary benefits in today's market." "Many employers--especially those in the Fortune 500--demand NCQA Accreditation as a condition of doing business. They want to maximize value, performance and transparency in their health care plan investment for their shareholders and for their employees and families."

Health plans will continue to seek accreditation to demonstrate their value, performance and quality to employers and consumers even if they have to fund accreditation fees out of the administrative expenses. We continue to object to including accreditation fees as quality improvement expenses.

- We believe that the administrative costs of wellness incentive programs should not be included as a quality improvement expense. Wellness premium reductions will reduce the denominator and cost-sharing reductions will increase the numerator, so only administrative costs are at issue. There is too little evidence about how and under what circumstances these programs actually contribute to improved health, and there is no effective oversight of them. There is potential for considerable discriminatory abuse. Moreover, the significant "discounts" permitted under the law could result in significant cost shifting and de facto underwriting, thereby undermining the advances in premium rating in the new law. Value-based insurance is an interesting but yet unproven concept. The term is not well defined, and therefore, it could be subject to considerable abuse. Until the idea is better defined and evaluated, it should not be considered a quality improvement.

In conclusion, we urge the E Committee again to proceed very cautiously in modifying any of the recommendations of the Subgroup. The Subgroup proposal is a carefully crafted compromise. No one group of interested parties—and certainly not consumer representatives—is completely satisfied with the result or got everything it wanted in the process. We refer you again to our earlier comments which identify issues where the subgroup rejected our proposals. Moreover, the recommendations of the Subgroup will need to be melded with the recommendations of the PPACA Actuarial Subgroup. Their recommendations also represent compromises and must be read in tandem with the recommendations of the Health Reform Subgroup. Although individual pleas of industry may seem reasonable on their face, therefore, changes in the current recommendations that are not offset by corresponding changes favoring consumers will upset a delicate balance. Such changes would be like pulling a thread from a carefully woven fabric.

We continue to appreciate the carefulness with which the NAIC has approached this difficult task and the seriousness with which you have taken our concerns and the charge that Congress has given you.

Sincerely,

Timothy Jost
Wendell Potter
Stephen Finan
Bonnie Burns
Mark Schoeberl
Georgia Maheras
Stacey Pogue
Brendan Bridgeland
Joe Ditré
Kim Calder