

Via Email Transmission

August 11, 2010

Marcy Morrison
Colorado Commissioner of Insurance
Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

RE: Medical Loss Ration Definitions before NAIC

Dear Commissioner Morrison:

The organizations listed below write 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 and approved by the E Committee.

We attach a letter dated July 28, 2010, to Commissioner Cline from a number of the consumer funded representatives to NAIC. We fully support the recommendations outlined in that letter. We too, strongly support the work of the E Committee and its Subgroup and are concerned about the widely publicized letter published by AHIP calling for significant changes in the recommendations of that Committee.

We agree that the Subgroup has resolved many contentious and difficult issues. The process has consistently been inclusive, participatory, thoughtful, and scrupulously attentive to the intent of Congress in drafting 2718. The subgroup's recommendations were passed unanimously by the E Committee. We believe that the result they have reached is on the whole reasonable, and urge the NAIC to hold to these decisions and not reopen the discussion.

The definition of Medical Loss Ratio is critical to controlling health care costs and achieving transparency. Consumers are entitled to be well informed about the products they are being required to purchase and those products ought to be required to deliver value. The calculation of medical and administrative costs should be fully transparent and clearly defined. There is no reason, in our view, why anything not directly related to patient care and clinical quality should be included in the medical costs category. Ambiguity in these definitions will undoubtedly lead to uncertainty, difficulty of enforcement, and lack of uniformity between health plans and across states. Such ambiguity ultimately hurts consumers who ought to be able to depend on clear definitions and enforceable provisions about this important calculation- which in the end is one measure of the value of the medical care they receive.

Commissioner Marcy Morrison
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We thank you for your attention to this letter and our request, as well as your continuing responsiveness to these issues and support of health care consumers. We hope you can support the recommendations. Please let us know if there is anything we can do to assist you as this and other important discussions move forward at NAIC.

Very truly yours,

The Bell Policy Center
Chronic Care Collaborative
Colorado Academy of Family Physicians
Colorado Center on Law and Policy
Colorado Children's Campaign
Colorado Consumer Health Initiative
Colorado Cross Disability Coalition
Colorado Medical Society
Colorado Mult-Ethnic Cultural Consortium
Colorado Progressive Coalition
Family Voices Colorado
Health Care for All Colorado
KEENE Research & Development
Mental Health America of Colorado
National Multiple Sclerosis Society- Colorado Chapter

Contact: Elisabeth Arenales, Esq., Health Care Program Director
Colorado Center on Law and Policy
789 Sherman Street, Suite 300
Denver, CO 80203
(303) 573-5669 x 302
earenales@cclponline.org

cc: Governor Bill Ritter, Jr.
Lorez Meinhold, Director of Health Reform Implementation
NAIC Commissioner Jane Cline and members of the NAIC Executive Committee

July 28, 2010

Commissioner Jane Cline, Members of the NAIC Executive Committee and Plenary

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

VIA ELECTRONIC MAIL

Dear Commissioner Cline, Executive Committee Members, Commissioners:

The 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 and approved by the E Committee. We are writing to express our support for the work of the E Committee and its Subgroup and express our concern regarding a widely publicized letter published by AHIP last week calling for significant changes in the recommendations of that Committee. We have filed numerous detailed comments earlier on many issues raised by the blank 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 E Committee 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. Their recommendations were passed unanimously by the E Committee. We believe that the result they have reached is on the whole reasonable, and implore the NAIC to hold to these decisions.

We urge the Executive Committee to proceed very cautiously in modifying any of the recommendations of the Subgroup and E Committee. Indeed, we believe that they should be accepted as drafted. 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. The Subgroup worked collaboratively, however, to achieve a balanced process. 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, 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.

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 (plus their

investment income) 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 specific issues raised by insurers:

- We endorse the Subgroup’s decision to reject the position supported by AHIP that the IOM definition of quality, as found in ACA section 3011, be used to define activities that improve quality of care. AHIP is arguing again in its most recent letter that the 3011/IOM definition be used for 2718. 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, efficiency, and equity. The subgroup properly focused on sections 2717 and 1311, the ACA sections dealing with insurer quality improvement efforts. Congress knew what it was doing when it specifically limited 2718 to insurer-initiated attempts to improve health care, and did not mean to include in that definition efforts to assure the quality of health insurance products themselves, including cost control or fraud prevention efforts. It certainly did not intend to address the broad issues of efficiency and equity raised by the IOM definition and captured in 3011.
- We strongly support the Committee’s decision to not allow issuers to claim their fraud prevention and detection expenses as quality improvement expenses. Including these expenses as quality improvement expenses would be wholly contrary to the language of the statute and the intent of Congress. We are concerned, moreover, 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. We believe that clear definitions are needed to assure that they do not. We urge the Executive Committee to tighten the definition of fraud.

- We 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.

Moreover, while the industry talks only about costs of implementing ICD 10, they do not mention (or account for) savings, e.g., in lower payments to providers through better tracking of services actually delivered, reduced ability to "buff" charges, reduced claims paid, fewer fraudulent claims, and more accurate processing of claims and therefore fewer rejected claims. If the insurers had to report their net costs of the conversion, it is likely there would be none. Businesses adopt these types of cost containment activities to lower costs on a net basis.

- 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 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 revenue. It would be grossly unfair to allow insurers to subtract these taxes from their premium revenue while not having to account for the investment income on which these taxes are based. Moreover, section 2718 provides that taxes are excluded from premium revenue. Taxes not attributable to premium revenue cannot be excluded from it, therefore section 2718 prohibits subtraction of taxes on investment income. The industry's argument that the federal tax exclusion extends to all taxes they pay, including taxes on investment income, would seem to mean that the taxes that insurers pay on premiums from other lines of business should also be subtracted from health insurance premium revenue. This simply cannot be what Congress intended. Only taxes on premium revenue should be excluded, not other taxes paid by insurers. (Alternatively, investment income should be considered premium revenue, since its ultimate source is premiums, and be counted in the denominator).
- 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

- We support the Committee’s decision to allow insurers to count the monitoring, measuring and reporting costs that they incur for maintaining accreditation and for reporting HEDIS and CAHPS data as quality improvement expenses, but not accreditation fees. 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 HEDIS and CAHPS and quality measurement and reporting facilitate quality improvement, the remaining standards focus are intended to assure the quality of the insurance product, not of health care. 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. It is appropriate that insurers be able to claim monitoring, measuring, and reporting costs related to accreditation, but it is not appropriate to including accreditation fees as quality improvement expenses.

- We support the Committee’s decision not to include the administrative costs of wellness incentive programs 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.

- We support the Committee’s decision to include agent and broker commissions as administrative expenses. The question of whether they should be included was raised orally in June during the Subgroup proceedings by a representative of Cigna, who asserted on a call that agent/broker commissions should not be counted as part of premiums for the MLR denominator or as administrative expenses for the MLR numerator. We found this position surprising, as the industry had consistently argued that the historically high cost of agent/broker commissions were a primary reason why a transition is needed to the statutory MLRs to avoid destabilization of the nongroup market. The Subgroup rejected this position out of hand.

It is clear that Congress intended agent/broker commissions to be counted as administrative costs for purposes of the MLR. On December 20, 2009, hours before the Senate passed PPACA, Senator Nelson, the former insurance commissioner of Florida, explaining how the legislation made health insurance more affordable, stated on the Senate floor:

I want to give one specific example. It is a technical term in the insurance industry called the "medical loss ratio." It is the ratio in what an insurance company actually pays out in medical claims as opposed to what it pays for administrative expenses such as marketing, insurance agent commissions, underwriting, and an insurance company's profit. . . . What this amendment, . . . says, is it causes a specific ratio so you are getting a high amount of return on the insurance premium dollar. . . . And the balance, . . . is going to things such as administrative expenses, paying for insurance agents, commissions, paying for their profit. . .

155 Cong. Rec. S13558, S13626-S13627.

Section 1301(a)(1)(C)(iii) of the ACA, states that the issuer of a qualified health plan must agree “to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent.” Obviously Congress understood that agent/broker commissions were part of the premium rate charged by health insurers. We support the Subgroup in maintaining this position.

While we believe that the drafting process should not be reopened, if the Executive Committee does make any adjustments in the proposed blank, we would request consideration of the following:

- 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 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 by insurers, including health-data, quality-related information, 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 urge the Executive Committee to assure that all information submitted by insurers to document MLR compliance and calculations be open. The blank provides on page 18 for a supplemental, regulator-only, filing describing how quality improvement expenses were calculated. This information must be public if the process is to have integrity.

Finally, although the handling of the transition to the MLRs between 2011 and 2014 is not addressed by the blanks proposal, it is addressed by the statute, which gives HHS the discretion to reduce the MLRs on a state by state basis as necessary to prevent destabilization of the nongroup market. This issue is being addressed by Steven Ostlund's PPACA Actuarial subgroup, and that Subgroup's IRD041 presents a viable solution to the problem. This issue should be addressed through that group's process, in the context of the other issues they are addressing.

Congress asked the NAIC to establish the definitions and methodologies for the MLR process because of the NAIC's technical expertise in insurance matters. The Subgroups have done an exceptional job in applying that technical expertise to the difficult questions raised by the MLR process. Insurance commissioners, elected or appointed, are also subject to political pressure. We realize that the industry is putting considerable pressure as we speak, and that the ACA is not popular in many of your states. It would be a great tragedy, however, if at this late date the NAIC process turned from an expert to a political process. It would in fact be a betrayal of the trust Congress has placed in the NAIC. We urge you to strongly resist the temptation to go this direction.

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
Bonnie Burns
Elizabeth Abbott
Mark Schoeberl
Georgia Maheras
Stacey Pogue
Stephen Finan
Barbara Yondorf