July 15, 2010
VIA EMAIL knoonan@naic.org

Jane L. Cline
Chair, Executive Committee

RE: Comments on exclusions to definition of “Quality Improvement” expenses

Dear Chairwoman Cline and Members:

I am writing on behalf of the American Association of Preferred Provider Organizations (AAPPO), the leading national association of preferred provider organizations (PPOs) of insurers and non-risk PPO networks. AAPPO’s 1,065 members seek to advance the awareness of the benefits of greater access, choice, and flexibility that PPOs bring to the over 199 million Americans currently covered by PPOs today. Sixty-nine percent of Americans with health care are covered by PPOs.

AAPPO would like to express its appreciation for the opportunity to participate as an interested party in Subgroup E calls, and for the opportunity to provide comments throughout the process. AAPPO has reviewed the final proposal that was voted on and accepted at the July 1, 2010 meeting, and respectfully requests the Committee to consider the enclosed clarification language which will assist in fostering innovation in the Supplement Health Care Exhibit – Part 3.

AAPPO is fully aware that qualifying “Quality Improvement” expenses should be grounded in evidence-based medicine. As this evolves as the platform for clearly identifying any type of quality improvement expense in the delivery of health care for the future, it will also be necessary to consider innovation in the areas of network management, credentialing and accreditation. These are very broad “umbrella industry terms” used to describe multiple processes and activities being performed as part of functions that vary considerably among stakeholders and are evolving very quickly. While the proposal clearly outlines what expenses for these functions are unquestionably administrative or cost containment, no consideration is given to the innovations already underway in these areas which are wholly evidence-based medicine and will result in demonstrating health improvements.
Network management serves as an excellent example to demonstrate the innovations in quality improvement activities. This function is evolving to include many varied care management programs and activities that are coordinated between insurers and providers to support improved patient care. Additionally, credentialing is evolving beyond simply verifying credentials and is beginning to include many performance based activities. Accreditation programs are also evolving and clearly demonstrate many varied coordinated care activities that produce verifiable results and achievements.

Accordingly, we request the exclusionary language in Part 3 be clarified so as not to stifle innovation.

We appreciate your consideration of our comments. If AAPPO can provide any additional resource information to substantiate our comments please do not hesitate to contact me.

Thank you for your consideration.

Very truly yours,

Karen Greenrose.
President and CEO
Except to the extent that they conform to the definition of “Quality Improvement expenses,” the following items are broadly excluded as not meeting the definitions above:

- Healthcare Professional Hotlines (except as noted above);
- All retrospective and concurrent Utilization Review;
- Fraud Prevention activities (all are reported as cost containment, but Part 1, Line 4 includes MLR recognition of fraud detection/recovery expenses up to the amount recovered that reduces incurred claims);
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
- Provider Credentialing;
- All Accreditation Fees;
- Costs associated with calculating and administering individual enrollee or employee incentives; and
- Any function or activity not expressly included in Columns 1 through 5.
American Association of Preferred Provider Organizations

August 11, 2010

VIA EMAIL cavila@naic.org

Jane L. Cline
Chair, Executive Committee

RE: Comments on Amendments to the Draft MLR "Blanks" Proposal

Dear Chairwoman Cline and Members:

I am writing on behalf of the American Association of Preferred Provider Organizations (AAPPO) to offer comments on the Blanks Proposal reflecting discussions with the the U.S. Dept. of Health and Human Services (HHS). AAPPO is the leading national association of preferred provider organizations (PPOs) of insurers and non-risk PPO networks. AAPPO’s 1,065 members seek to advance the awareness of the benefits of greater access, choice, and flexibility that PPOs bring to the over 199 million Americans currently covered by PPOs today. Sixty-nine percent of Americans with health care are covered by PPOs.

While we have offered our comments before, we believe that the language we offered to the Committee July 17, 2010, is worthy of reconsideration based on some of the changes reflected in this most recent proposal. AAPPO has reviewed the new proposal and respectfully requests the Committee to consider the enclosed clarification language which will assist in fostering innovation in the Supplement Health Care Exhibit – Part 3. In the new proposal, accreditation fees and other items have been removed from the list of items broadly excluded from consideration as Quality improvement expenses, and are now included as quality improvement activities in the Medical Loss Ration computation. Our suggested language clarifies that activities that meet the definition of quality improvement expenses should be considered appropriate in instances when they may be confused with, or a component part of, fees or services broadly excluded. This is especially appropriate as, for example, accreditation expenses are incurred by PPO networks on behalf of carriers.

AAPPO is fully aware that qualifying “Quality Improvement” expenses should be grounded in evidence-based medicine. As this evolves as the platform for clearly identifying any type of quality improvement expense in the delivery of health care for the future, it will also be necessary to consider innovation in the areas of network management, credentialing and accreditation. These are very broad “umbrella industry terms” used to describe multiple processes and activities being performed as part of functions that vary considerably among stakeholders and are evolving very quickly. While the proposal clearly outlines what expenses for these functions are unquestionably administrative or cost containment, no consideration is
given to the innovations already underway in these areas which are wholly evidence-based medicine and will result in demonstrating health improvements.

AAPPO understands that “access fees” as defined as leasing a network world be considered a cost containment expense. However, there are numerous other network management services that serve as an excellent examples in demonstrating the innovations of quality improvement activities. Network Management services continue to evolve to include many varied care management programs and activities that are coordinated between insurers and providers to support improved patient care. Additionally, credentialing is evolving beyond simply verifying credentials and is beginning to include many performance based activities. Accreditation programs are also evolving and clearly demonstrate many varied coordinated care activities that produce verifiable results and achievements.

Accordingly, we request the exclusionary language in Part 3 be clarified so as not to stifle innovation and to make sure that expenses otherwise defined as quality improvement are not appropriately allowed in the Medical Loss Ratio computation.

We appreciate your consideration of our comments. If AAPPO can provide any additional resource information to substantiate our comments please do not hesitate to contact me.

Thank you for your consideration.

Very truly yours,

Karen Greenrose.
President and CEO
Suggested language for the Draft MLR "Blanks" Proposal

Except to the extent that they conform to the definition of “Quality Improvement expenses,” the following items are broadly excluded as not meeting the definitions above:

- All retrospective and concurrent Utilization Review;
- Fraud Prevention activities (all are reported as cost containment, but Part 1, Line 4 includes MLR recognition of fraud detection/recovery expenses up to the amount recovered that reduces incurred claims);
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
- Provider Credentialing;
- Marketing expenses;
- Costs associated with calculating and administering individual enrollee or employee incentives; and
- Any function or activity not expressly included in Columns 1 through 5.
August 4, 2010

Ms. Jane L. Cline  
President, National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, MO 64108-2662

Dear Ms. Kline:

As a consumer organization with millions of members throughout the United States and the territories, AARP was a strong and forceful advocate for health reform legislation. We continue to have a keen interest in seeing that implementation of this legislation meets the intent of the law—to provide access to affordable, high quality health care to all Americans. In that connection, we are writing concerning the above referenced section of the law that applies to medical loss ratios (MLR).

The Accountable Care Act (ACA) requires health plans to provide a “clear accounting for costs”, including “the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums.” Health plans must report the percentage of total premium revenue spent on (1) reimbursement for clinical services provided to enrollees; (2) activities that improve quality; and (3) all other non-claims costs.

Together with mandatory premium rebates for products that fail to meet the minimum standard, MLRs can serve as an incentive for health plans to reduce administrative overhead, thereby saving money for both consumers and taxpayers. Great caution is needed, however, in implementing the federal MLR standards to ensure intended outcomes. If key definitions, levels of aggregation, and other methodological aspects of calculating MLRs are not well constructed and applied, the resulting ratios could erode value for consumers by tolerating excessive spending on activities that contribute little or nothing to improve care. On the other hand, if insurers are too tightly restricted in what can be included under the definitions of medical and quality-related expenses, important quality improvement initiatives – many of which were sought by Congress in provisions throughout ACA– could be discouraged. Below are illustrations of activities we think contribute to quality improvement— and which therefore should be recognized as medical expenses in the MLR calculation— and those that do not.

Section 2717 (a)(1)(A) of the ACA includes examples of activities that improve quality of care. These are: quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical home model for treatment or services. These activities provide a useful sense of what Congress intended as legitimate quality activities. They should be recognized as legitimate quality activities when health plans invest in them directly—for example, through health plan programs reporting on the performance quality of participating providers—or when health plans require providers to do them—for example, by designing coverage and reimbursement structures in such a way that providers have the incentive to create and participate in performance measurement and reporting programs.
In addition, AARP believes several activities that will enable or facilitate implementation of the activities delineated in the legislation should also be recognized. Examples include, expenses associated with: accreditation; activities that improve patient safety and reduce medical errors, such as initiatives to prevent complications or infections and reconciliation of medications; activities to prevent or reduce hospital readmissions; activities to enhance electronic information sharing between and among providers via health information technology; health information technology that enables patients to have electronic access to their medical records and that provides clinical decision support to clinicians.

With respect to “transparency,” we support classification as “quality improvement expenses” of the costs health plans incur related to reporting to their enrollees or to the public providers’ performance on standardized, nationally endorsed measures, including the costs associated with fielding patient experience surveys. Such reporting can motivate and guide provider quality improvement and can help consumers choose high-quality providers. Therefore, costs for data collection, auditing and data transmission to ensure that data are properly aggregated and validated are legitimate quality expenses.

AARP does not support inclusion of the following activities or expenses: fraud and abuse expenses; utilization review activities that are conducted merely for cost containment purposes (e.g., retrospective and concurrent reviews, medical authorization programs); costs associated with establishing or maintaining claims adjudication systems or technology costs associated primarily with paying claims or complying with administrative requirements that are HIPAA-related; costs associated with managing a provider network, including provider contracting; provider credentialing; costs of conversion to ICD-10; costs associated with internal and external reviews of complaints and appeals; and costs associated with health and wellness incentive programs that are not evidence-based. We note that organizations such as the National Committee for Quality Assurance have programs that certify organizations and programs that meet specified standards in wellness and health promotion, disease management, and other areas that could be useful in determining whether an insurer’s activities in these areas are designed to improve quality.

We stress that AARP does not support “creative accounting” or other practices that would designate routine business activities as quality-related. We want to underscore the importance of balancing the need to encourage quality improvement while preventing plans from simply reclassifying certain administrative expenses as “quality improvements.” We fully appreciate the challenge in striking the proper balance, and believe that development and enforcement of MLR policies will require refinement over time as we learn more about health plan activities that most effectively improve quality.

Unfortunately, the evidence and knowledge base for quality improvement is inadequate. Until this evidence base is enlarged, there are instances where well-founded, widely-accepted, expert opinion must be a sufficient basis for health plans to implement activities intended to improve quality and, in turn, have them classified as “quality improvement activities.” AARP believes that activities should not be classified as “quality improvement activities” unless there is a sound basis, either from experimental research or from widely-supported independent expert opinion, for believing that such activities can be expected to improve health care quality and increase the likelihood of desired health outcomes. Qualified quality improvement expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by
recognized professional medical associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations.

In conclusion, it is noteworthy that section 2718 is titled “Bringing Down the Cost of Health Care Coverage” while subsection (b) addresses “Ensuring That Consumers Receive Value For Their Premium Payments.” Both headings express clear and compelling objectives that are of critical importance to our members. It is essential for consumers to realize value for their premium dollars spent; value factors cost and quality into the equation, whereas premium reduction simply considers price. Although the MLR statistic may be useful to incent administrative efficiency, reduce marketing costs, prevent excessive profits, and promote pricing transparency, it may not be necessarily the best statistic to assess the value of quality improvement initiatives. Therefore, we must proceed carefully. Reliance on the MLR as a determinant of high or low quality is contentious. One leading health economist has observed that, “High ratios can be achieved either through a large numerator (high medical expenditures) or through a small denominator (low insurance premiums). The medical loss ratio, as a ratio of the two, can be measuring the impact of medical market competition on expenditures or of insurance market competition on premiums.”¹ It was further pointed out that neither premiums nor expenditures by themselves indicate quality care. Careful monitoring of the effects of implementing Section 2718 will be essential and we urge you to acknowledge in your recommendations to the Department of Health and Human Services (HHS) the need to review these effects regularly to ensure there are no unintended consequences.

Thank you again for the opportunity to comment on this important matter. If you have questions, please contact Nora Super on our Federal Affairs staff at (202) 434-3770.

Sincerely,

David Certner
Legislative Counsel & Legislative Policy Director
Government Relations & Advocacy

cc: Steven Larsen, U.S. Department of Health and Human Services
    Commissioners, National Association of Insurance Commissioners

¹ James C. Robinson, “Use And Abuse of the Medical Loss Ratio to Measure Health Plan Performance,” Health Affairs, Volume 16, Number 4, pp.176-187.
August 10, 2010

Jane L. Cline
President, National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Re: Medical Loss Ratios – Section 2718 of the Public Health Service Act (PHSA)

Dear Commissioner Cline:

AARP and the National Partnership for Women & Families appreciate the opportunity to offer comments on the amendments to the Life and Health Blanks Proposal that was released last week.

**Ensure full transparency of the process**

First, we urge you to make public the schedule insurers use to report their quality improvement activities. As has been evident during the development of recommendations concerning appropriate items for inclusion in the numerator of the medical loss ratio (MLR), there is tremendous interest among all stakeholders on this issue, and the public deserves the opportunity to determine whether Section 2718 is being implemented as Congress intended. Moreover, development and enforcement of MLR policies will require refinement over time as we learn more about health plan activities that most effectively improve quality. The public will have confidence in this process only if it is fully transparent.

**Recognize measurement and public reporting of clinical effectiveness and patient experience as legitimate quality improvement activities**

We urge you to include a clear and explicit statement that activities to measure and publicly report on the quality of performance of doctors, hospitals, and other health care providers on measures of clinical quality and patient experience are considered numerator activities. While an argument could be made that these activities are already included, we believe there should be left no room for doubt that these activities are recognized contributors to quality improvement. Such a statement could be added to the listing of items in Column 1 at the bullet that now reads, "Quality reporting and documentation of care in non-electronic format." The revised bullet would say, "Quality reporting and documentation of care in either electronic or non-electronic format, including measurement and public reporting on the quality of performance of doctors, hospitals, and other health care providers on scientifically valid measures of clinical quality and patient experience."
We also suggest that you clarify item 1 in Column 5 to be explicit that costs for reporting on patient experience are recognized along with those for clinical effectiveness. We believe the intent is to include both types of measures, but, as currently written, item 1 only identifies costs associated with clinical effectiveness (although CAHPS, which is a patient experience survey, is used as an illustrative example.)

Improving Health Care Quality Expenses

Under the general definitions section, Improving Health Care Quality Expenses, we note that the revised proposal deleted “other nationally recognized health care quality organizations” from the list of bodies that might be looked to as having identified legitimate quality improvement activities. This deletion would preclude inclusion of practices endorsed by the National Quality Forum (NQF). Since the NQF employs a multi-stakeholder consensus process, the recommended practices are broadly supported. Therefore, we urge either reconsideration of the deletion of the term, “nationally recognized organizations” or add an explicit reference to the NQF.

Wellness and Health Promotion Activities

Please note that under Column 4, Wellness and Health Promotion Activities, the 5th bullet incorrectly mentions that the current allowable incentive amount under HIPAA is 30 percent. The current allowable amount is 20 percent. The higher amount does not go into effect until 2014.

Thank you again for your consideration of these comments and suggestions. Should you require further clarification, please contact Nora Super of AARP’s Federal Affairs staff at (202) 434-3770 or Kirsten Sloan of the National Partnership at (202) 238-4815.

Sincerely,

David Sloane
Senior Vice-president
Government Relations & Advocacy

Debra L. Ness
President
National Partnership for Women & Families
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.
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 the blank 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…


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
Avila, Cindy D.

From: Jody Dugan [judy@consumerwatchdog.org]
Sent: Tuesday, August 10, 2010 12:37 PM
To: Avila, Cindy D.
Cc: Webb, Brian R.

Subject: Consumer Watchdog comment on late changes to Blanks proposal

To: NAIC President Jane L. Cline
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: Changes to NAIC Life and Accident & Health Blank and negative effect on MLR

Recent changes to the document that will guide what health insurers can define as Health Quality Improvements (and thus include in the medical loss ratio under PPACA) will largely diminish consumer protections and benefit insurance companies. The late and anonymous changes appear almost entirely to be the opposite of positions urged by the NAIC's own consumer representatives in their detailed letter of July 6. As the changes were made after the NAIC Financial Condition Committee approved the Blanks proposal by the E committee subgroup led by Lou Felice, we believe that they must receive a fuller public hearing, including knowledge of the source of each substantive change, before a final vote of the NAIC joint executive committee.

Consumer Watchdog protests these changes and asks that they be reversed.

In addition, we protest the lack of transparency regarding the changes. The NAIC's release of the revised document, signed by NAIC staff member Brian Webb, says the changes "[Reflect] discussions among members and with the U.S. Dept. of Health and Human Services (HHS)." Yet the document revisions do not state the source of individual changes. We ask that you identify the changes requested by HHS, if any, and those requested by commissioners or staff, identified individually. Otherwise, the amendments do not comport with the transparency promised when the NAIC took on the task of developing proposed regulations for approval by HHS.

The changes to which we object include:

+ **Inclusion of "all accreditation fees"** as quality improvements, without restriction. (Supplemental Health Care Exhibit, Part 3 a, [page 14])
   In a July 6 letter to the full committee (also attached, as PDF) the NAIC's own consumer representatives urged the committee against this inclusion, because while it may reassure prospective customers and investors, accreditation has nothing to do with health quality improvement;

+ **A potentially great expansion of inclusion of prospective utilization review** as quality improvement rather than as a claims adjustment expense, which is counted as administrative. The new language (note b, page 16) states:

   Prospective Utilization Review: Expenses for prospective utilization review should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities, AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.

   This is like saying, "Torture of prisoners is not allowed to the extent that it is banned by the Geneva Convention AND has not been approved by an officer of the rank of Major or above." Considering that national accreditation bodies have close ties to insurers, it is predictable that such recognition "by a recognized accreditation body" will expand to include much of what insurers desire to include as HQI.

+ **New inclusion in MLR of "Public health marketing campaigns that are performed in conjunction with state or local health departments"** This is the sort of activity that entirely blurs
the line between marketing and health messages, and should only be recognized as a possible deduction to premium revenue to the extent that it is in lieu of premium taxes by the state.

**Inclusion in MLR of "Actual rewards/incentives/bonuses/reductions in copays, etc."** tied to wellness programs." This, as the NAIC consumer representatives' letter noted, can be used as a sort of faux underwriting to cherry-pick the healthiest large and small groups and is not proven to improve health quality. The rewards are likely to be tied to cost reductions.

There are other changes that broaden permissiveness and add vagueness to what may be included as part of health quality improvement, particularly in regard to "wellness programs," which may be thinly disguised marketing. We ask that these changes be reversed in advance of a full executive/plenary vote.

Judy Dugan, research director
judy@consumerwatchdog.org
310 392-0522 ext. 305
cell 213 280-0175

www.consumerwatchdog.org
www.oilwatchdog.org
August 10, 2010

Commissioner Jane L. Cline
President, National Association of Insurance Commissioners
and
NAIC Executive and Plenary Committee
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Comments regarding suggested amendments to Blanks Proposal re Medical Loss Ratios, Section 2718 of the Public Health Service Act

Dear Commissioner Cline:

This is a letter with comments from Consumers’ CHECKBOOK/Center for the Study of Services, a nonprofit consumer organization. In our earlier comments letter, dated July 30, 2010, we provided background on our organization, and the experience we have gained in our more than 30 years of providing the public with evaluations of the performance of health plans, physicians, hospitals, and other service providers.

We focus in this letter on two points. First, it is of great importance that the Blanks form makes clear that health plan expenses related to measurement and public reporting on the quality of performance of doctors, hospitals, and other health care providers on scientifically valid measures of clinical quality and patient experience should be classified as “quality improvement expenses.” Second, strongly believe that there should be a policy that filings health plans make with the Secretary of HHS and with insurance commissioners related to medical loss ratio calculations must be open to the public.

Quality Measurement

On the first point, we propose that, for clarification, the bullet item under Column 1 that now reads “Quality reporting and documentation of care in non-electronic format” be changed to read as follows:

- Quality reporting and documentation of care in either electronic or non-electronic format, including measurement and public reporting on the quality of performance of doctors, hospitals, and other health care providers on scientifically valid measures of clinical quality and patient experience.

We believe that this is actually a clarification of the intent of the existing language. It is not opposed by the NAIC consumer representatives. And it is consistent with the provisions on quality reporting on the specific types of activities addressed under Columns 2, 3, and 4.

Measurement and public reporting on the quality of performance of health care providers is one of the most powerful available tools for improving quality in the health care system. Such activities can guide and motivate providers to improve and can assist consumers in the selection of providers. Some health plans have been leaders in such measurement and reporting—moving more aggressively than either provider organizations or governments on this front.

Some plans have their own measurement and reporting activities. Others participate in collaborative programs. At the national level there are collaborative efforts like the High-Value Health Care Project,
of the Engelberg Center at the Brookings Institution, which is working to lead the aggregation of data from health plans and government payers to make sure consistent information becomes widely available to consumers, providers, and public and private payers of health care. At the regional level, there are efforts like the work of Massachusetts Health Quality Partners, which uses data and financial support from health plans to calculate performance measures for medical practices on clinical measures—including measures of care of heart disease, asthma, and diabetes—and uses data and financial support from health plans to conduct surveys and produce public reports on patient experience with medical practices—including reports on how well doctors communicate, coordinate care, and give preventive care and advice. Reports are available free to the public at www.mhqpp.org.

Our own experience includes programs we have sponsored in which leading health plans have collaborated with one another and with organizations like the Kansas City Quality Improvement Consortium and Healthy Memphis Common Table to identify samples of patients to survey about their experience with their doctors. The collaborating plans share in the survey and analysis costs by purchasing licenses to use the survey results in their provider directories and other programs—including information on how well each physician listens, explains things, maintains familiarity with the patient’s medical history, makes care accessible when needed, and performs on other dimensions that patients can judge. Reports are available free to the public at the websites of collaborating organizations and at www.checkbook.org/patientcentral.

But there are considerable pressures on plans not to engage in such measurement and reporting, and there are substantial costs. Even now, many plans choose not to participate. It would be a major disincentive for participation in such activities if there were any ambiguity as to whether these expenses will be recognized as “quality improvement expenses.”

Public Disclosure of Plan Filings Related to Medical Loss Ratios
The committees and staff members who have been developing the policies and the Blanks form related to medical loss ratios have devoted a great amount of effort and intelligence to getting it all right. But it is evident that there are grey areas—that there will be a need for wise interpretation of the rules in response to the actual filings health plans make, in order to ensure that the spirit of the law and the public interest are reflected.

This process will benefit from openness. It will be important for as broad a group as possible of experts and members of the public to see the actual factual situations that the commissioners have to deal with. This type of public scrutiny can be expected to lead to the development of strong, well-reasoned precedents; enlightened revisions and clarifications of the rules; and sharing of wisdom across jurisdictions.

We and other consumer organizations strongly urge you to express a policy that the filings of plans related to medical loss ratios be made public.

We appreciate the opportunity to comment.

Yours truly,

Robert M. Krugoff, President
Consumers' CHECKBOOK/Center for the Study of Services
STANDARDS FOR MEDICAL LOSS RATIOS SHOULD BENEFIT THE PUBLIC

August 11, 2010

The Honorable Kathleen Sebelius
Secretary, Department of Health and Human Services
Hubert Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Attn: Brian Webb, NAIC, bwebb@naic.org and cavila@naic.org

Re: Medical Loss Ratio (MLR) "Blanks" proposal by the Financial Condition (E) Committee, NAIC

Dear Secretary Sebelius:

The Affordable Care Act (ACA) empowers the Secretary to define the Medical Loss Ratio (MLR) in a way that benefits the public. We urge you to implement regulations that will help to set affordable premiums and bring down health care costs, by providing incentives to the health insurance industry to operate efficiently and to negotiate assertively with health care providers, rather than simply passing on cost increases to consumers.

We are concerned that the standards most recently proposed for review by the National Association of Insurance Commissioners (NAIC) include an edit that would allow the insurance industry to count marketing campaigns performed in conjunction with state and local public health departments as medical expenses. This reference appears in the Medical Loss Ratio (MLR) "Blanks" proposal by the Financial Condition (E) Committee of the NAIC dated June 29, 2010. We consider this an avenue to inflate charges unduly, and ask you not to accept this proposal.

The NAIC is charged with developing proposed regulations, and reporting its proposals to your office. We offer these comments in the hope that the NAIC will more equitably balance the interests of the public and of the insurance industry, and we further ask that you, Madame Secretary, make an independent assessment of their recommendations.

The EQUAL Health Network brings together partners from public health, women’s health, the faith community, seniors and the public on a national basis to advocate for Equitable, Quality,
Universal, Affordable health care. We have been active supporters of the ACA, and submitted formal comments on the MLR to HHS on May 14, 2010.

We outline here a brief summary of the ACA provisions regarding the Medical Loss Ratio, the present proposals under consideration by the NAIC, and recommendations for the HHS’ regulations. The agency has established a popular track record of responding to and reining in insurance industry abuses. We appreciate your personal commitment to protecting and advancing the public's interest in access to affordable health care.

**The Law: ACA calls for Medical Loss Ratio That Controls Costs, Provides Value**

The stated objectives of Section 2718 of the Patient Protection and Affordable Care Act (PPACA) are "bringing down the cost of health care coverage" and "ensuring that consumers receive value for their premium payments." In pursuit of these aims, the law requires health insurance companies to spend at least 85% of premiums on patient care, a figure known as the “medical loss ratio” or MLR, and only 15% on administration and profit, in the large group market. In the small group market, the figures are 80% MLR and 20% for administration and profit. Companies must also report the calculations for their MLR. This rule is in effect until 2014, when health exchanges are set to begin. It applies to all health insurance plans, including grandfathered plans.

The aims of Sec. 2718 - low cost care that offers value to consumers – conflict with the financial imperatives of the health insurance industry, to maximize profits and returns to shareholders, as well as administration, including executive compensation. Proposals by the insurance industry call for calculating the MLR in a way that will frustrate the aims of the law. The MLR is a ratio, with all medical claims (in the numerator), divided by total premiums (in the denominator). A high MLR means that the insurance company is spending a relatively higher share of premium income on its members' medical care and less for administration and profit. A low MLR means that the insurance company is returning less in medical care benefits to its members while retaining more for executives and shareholders; this can also signal a solid opportunity for investors.

To fairly achieve an 85% MLR, a company would have to show that the amount spent on medical claims (in the numerator) is high relative to premiums. But companies can frustrate the intent of the law by defining medical claims to include other expenses, including expenses typically considered part of administration.

**Defining "Activities That Improve Health Care Quality"**

Section 2718 of the ACA defines clinical services (2718 (a)(1)) and activities that improve health care quality (2718 (a) (2)) as part of the numerator of the MLR, while non-claims costs (2718(a)(3)) reside on the administration side.
CARE COVERAGE.

“(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

“(1) on reimbursement for clinical services provided to enrollees under such coverage;

“(2) for activities that improve health care quality; and

“(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

“(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

This allows companies to count, among the 80 - 85% spent on medical care, "activities that improve health care quality" as a component of the MLR.

The insurance industry’s proposals ask the NAIC to define the MLR to its advantage, by counting marketing programs, including those with public health themes, as medical expenses, rather than the administrative expenses they clearly are. This is an open invitation to the industry to “game” the system.

The insurance industry has already stated its intention to game the system by raising premiums to make up for any constraints imposed by the new law; and has begun to game the MLR rules for its own gain. The Senate Commerce Committee has documented that, "At least one company, WellPoint, has already ‘reclassified’ more than half a billion dollars of administrative expenses as medical expenses, and a leading industry analyst recently released a report explaining how the new law gives for-profit insurers a powerful new incentive to ‘MLR shift’ their previously identified administrative expenses.”

Part of the justification for unfounded charges is the industry's incursion into activities such as alliances with disease management programs, which it attempts to characterize as a clinical benefit rather than administration and marketing.
NAIC committees have been working largely outside of the public’s view to draft standards. The committees’ drafts have been edited by sources not publicly identified to date. The draft proposal of June 29, 2010, includes the unattributed edits, shown below in **boldface and underline**, for items that may be considered medical expenses:

**Column 4 – Wellness & Health Promotion Activities**
Expenses for programs that provide wellness and health promotion activity as defined above (e.g., face-to-face, telephonic or web-based interactions or other forms of communication), including:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
- **Public health marketing campaigns that are performed in conjunction with state or local health departments:**
  - Actual rewards/incentives/bonuses/reductions in copays, etc. (not administration of these programs) **that are not already reflected in premiums or claims** should be allowed as QI with the following restrictions:
    - Only allowed for small and large employer groups, not individual business; and the expense amount is limited to **the same percentage as the HIPAA incentive amount** (currently 30%);

The ACA standard for including expenditures for non-clinical care as a medical expense (that is, in the numerator) is that it must “improve health care quality.” It is important to note this standard carefully. It does not legitimate including activities that improve the health of the public. This is the province of public health agencies. Contributions to public health endeavors are always welcome, particularly in the current climate of scarce resources. Insurance companies may consider collaborations with public health departments to be advantageous, in that successful programs will in the long run reduce medical claims. However there are three important issues to consider carefully in this regard:

1. Insurance companies and other for-profit businesses typically contribute to the work of public health departments by paying taxes. The ACA exempts certain insurance company taxes from inclusion in calculating the MLR; that is, taxes are subtracted from the denominator, making the companies’ income appear to be lower than it actually is. In this way, insurance companies already benefit from their contributions to public health departments, via taxes.
2. Any activity that qualifies for classification as a medical expense must meet the test of improving health care quality. This means that there must be evidence of measurable, demonstrable improvement. Marketing campaigns do not meet this standard.
3. While we do not support incentives to insurance companies to engage in areas beyond their function and expertise, we note that there are legitimate standards for community
public health education programs, most notably those promulgated by the Community Guide, which is affiliated with HHS. We commend this body to the attention of the NAIC.

Our own initial survey of health departments, and of insurance industry reports, found little evidence of current collaborations between insurance companies and public health departments. There are a few reports of insurance companies’ co-sponsorship of visible public health events. While this is certainly a legitimate optional activity, it does not justify skewing the MLR in ways that would raise premiums, or requiring the additional administrative effort to determine whether or not it is in itself an administrative or medical expense.

The NAIC and HHS should discourage efforts by insurance companies to create and benefit from insubstantial programs that masquerade as clinical treatments. These programs should be properly counted as the administrative expenses that they are. Otherwise, a proliferation of such programs, if regarded as clinical care, would have the exact opposite of the intended effect of the measure: it would cause health care expenditures to balloon, and dilute value for consumers.

The MLR Should Be Defined Narrowly

Regulatory standards defining costs of care and of quality improvement are important. An array of health insurers that are highly rated for quality regularly attain medical loss ratios of around 90 percent or more. (For example, major non-profit Massachusetts insurers often achieve and exceed that threshold; in recent years, Fallon, Harvard Pilgrim, and Tufts HMO have annually spent 87-91 percent of their premiums on care.) Many patient advocates supported requiring at least a minimum medical loss ratio of 90 percent, and an 85 percent standard is clearly easily attainable by insurers with large memberships.

The ACA standard applies only to insurers' premium revenues. Yet patients and payors should be equally concerned about how an insurer uses income from its investment of the sums it extracted from previous years’ patient premiums. A more appropriate standard would measure the share of insurers' total revenues devoted to care, as some analysts have urged.

Given these factors, it is vital that the "medical" and “quality improvement" portion of insurance expenditures be defined strictly, and that standardized reporting requirements be detailed to prevent miscategorization of administrative expenses. It is also vital that rate review and other pressures be strong enough to prevent insurers from simply raising premiums in order to offset the limit on their administration/profit share.

Continuous Monitoring, and Involvement of Patients and Advocates

It will be important to create an ongoing process to set and review the initial regulations which are required to begin in September, 2010. Public comment on this system's achievements and
limitations will provide important assessments of the system's success, and offer the groundwork for constructive and equitable adjustments to the rules.

Sincerely,

Ellen R. Shaffer, PhD MPH, Co-Director, EQUAL Health Network
Robert Mason, Policy Fellow, EQUAL Health Network

cc: Sen. Jay Rockefeller
    Jay Angoff, HHS

1 A review of states' rules on MLR, compiled by the National Association of Insurance Commissioners (NAIC) and published by America's Health Insurance Plans (AHIP), shows that most states do not use this definition, and define administrative expenses straightforwardly. State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations (as of April 15, 2010). AHIP.
2 Judy Dugan, Jerry Flanagan, Carmen Balber. Comments from Consumer Watchdog to NAIC on medical loss ratio rulemaking per Section 2718 of PPACA, May 10, 2010.
3 Committee On Commerce, Science, And Transportation, Office Of Oversight And Investigations, Majority Staff. Implementing Health Insurance Reform: New Medical Loss Ratio Information For Policymakers And Consumers. Staff Report for Chairman Rockefeller April 15, 2010.
http://commerce.senate.gov/public/?a=Files.Serve&File_id=d20644bc-6ed2-4d5a-8062-138025b998ef
August 11, 2010

Commissioner Jane L. Cline
President, National Association of Insurance Commissioners

Members of the Executive Committee and Plenary
National Association of Insurance Commissioners

Dear Commissioner Cline and Members of the Executive Committee and Plenary,

Families USA appreciates the opportunity to provide comments as an interested party to the National Association of Insurance Commissioners (NAIC) regarding the Financial Condition (E) Committee Blanks Proposal. Families USA is a nonprofit, nonpartisan consumer advocacy organization dedicated to the achievement of high-quality, affordable health care for all Americans. We view the integrity of the Blanks Proposal as critical to ensuring that the medical loss ratio (MLR) requirements included in section 2718 of the Patient Protection and Affordable Care Act (Affordable Care Act) effectively protect health care consumers as intended by Congress.

Families USA appreciates the transparent process that the NAIC subgroups have engaged in while drafting the Blanks Proposal. The resulting document reflects the input of the official NAIC consumer representatives and of many interested parties, including those representing the insurance industry and those representing consumer groups. We support that the Blanks Proposal has properly excluded expenses pertaining to Utilization Review, fraud prevention, provider contracting, provider credentialing, the adoption of the ICD-10 coding system, and other administrative functions from the category of “Quality Improvement (QI) expenses” in the MLR calculation. We also support the emphasis on objective measurability and verifiable results for QI expenses, which is critical to ensuring that consumers’ premium dollars are spent reasonably and effectively. However, we do believe that some improvements to the Blanks Document are necessary to adequately protect consumers under the MLR requirements in the Affordable Care Act.

Wellness Incentive Programs
The current Blanks Proposal includes a proposed amendment to add “actual rewards/incentives/bonuses/reductions in copays, etc.” in wellness programs to the QI category of the MLR calculation that, if adopted, would be detrimental to consumers. Families USA and many other consumer groups are deeply concerned about the effects of wellness programs that use cost-sharing or premium differentials as incentives to participate or to meet certain health

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outcomes on consumers’ access to health care. Many of these so-called wellness programs are nothing more than backdoor health status rating— they do not include sufficient supports to help people achieve health goals, but simply charge those who do not meet goals more than other enrollees for their health coverage or care.² We do not view these types of programs as initiatives that have a positive effect on health care quality. We are particularly concerned about the effect of these programs on low-income workers, who may not have the time or resources to participate and could face higher health care costs as a result. Additionally, we are not convinced that insurers truly expend funds to finance wellness program incentives. Instead, we have seen examples of programs that raise cost-sharing requirements for enrollees, and then require enrollees to participate in wellness plans or achieve health goals in order for their costs to return to the level at which they were previously.³ Given that we view wellness programs that use premium or cost-sharing differentials as a barrier to affordable coverage and care for consumers, we strongly oppose the inclusion of wellness incentives as QI expenses in the MLR calculation.

Further, the proposed amendment to the Blanks Proposal regarding wellness incentives states that the incentive amounts must be “limited to the same percentage as the HIPAA incentive amount (currently 30%).” However, wellness incentives are currently limited to 20 percent of premiums under HIPAA regulations.⁴ The Affordable Care Act does increase the allowable incentive amount from the current 20 percent to 30 percent, but this change is not effective until 2014. This change is described in section 2705(j)(3) of Subtitle C of the Affordable Care Act, and the effective date for Subtitle C is “plan years beginning on or after January 1, 2014,” as described in section 1255. Therefore, the amendment under discussion relating to wellness incentives should read “…the expense amount is limited to the same percentage as the HIPAA incentive amount (currently 20%).”

Prospective Prescription Drug Utilization Review
Families USA understands the rationale for including efforts to identify potential adverse drug interactions as a QI expense in the MLR calculation. However, we are generally opposed to the inclusion of Utilization Review as a QI expense and support the Blanks Proposal’s explicit exclusion of Utilization Review from the QI category. To ensure that only activities that serve the direct purpose of identifying adverse drug interactions are included in QI, we would prefer that the term “Utilization Review” be removed from the section of the Blanks Document describing QI initiatives to “improve patient safety and reduce medical errors.” Instead, the activities that the Blanks Proposal intends to capture here could be described as “patient safety programs designed to prevent adverse drug interactions.” For example, this category could include investments in health information technology to identify the prescription of counter-indicated drugs (if such health information technology is not accounted for elsewhere in the MLR calculation).

³ For example, see: Gary D. Robertson, N.C. Employee Health Insurance Plan Wants Costs Cut, Associated Press, September 20, 2009, available online at http://www.starnesonline.com/article/20090920/ARTICLES/0909209993?p=3&tc=pg. The article explains North Carolina’s state employee “wellness plan” as follows: The tobacco program, which will begin next July, will require smokers to quit or get into a cessation program if they want to keep the “standard plan” that requires patients to pay for 20 percent of a doctor bill after copayments and deductibles. Otherwise, the portion rises to 30 percent. At least nine other states charge or soon will charge higher premiums for state employees who smoke, according to the National Conference of State Legislatures. Starting in July 2011, enrollees with a body mass index – a weight-height ratio that determines whether a person is considered overweight – below 40 can stay in the more generous plan. The standard becomes 35 in July 2012.
Defining “Fraud and Abuse”
Families USA is concerned that, although the Blanks Proposal permits the subtraction of fraud and abuse detection expenses from fraud recoveries in the MLR calculation, it does not include a definition for fraud and abuse expenses or recoveries. Without a clear definition, we are concerned that insurers will account for a broad array of expenses and recoveries, such as those from adjusting erroneous overpayments, as fraud and abuse. Therefore, fraud should be clearly defined in the Blanks Proposal as only activities in which there was intent to deceive.

Taxes, Licenses, and Fees
Section 2718 of the Affordable Care Act states that “federal and state taxes and licensing or regulatory fees” may be excluded from the denominator of the MLR calculation. There has been extensive debate regarding the range of taxes that Congress intended to exclude from the MLR calculation under this section of the statute. On August 10, 2010, the chairs of multiple congressional committees that had a direct role in drafting the Affordable Care Act clarified their intent with a letter to the Secretary of Health and Human Services. The letter states that federal taxes excluded from the MLR calculation should only be those related to the provision of health insurance referenced in the Affordable Care Act, not income or payroll taxes. Therefore, the Blanks Proposal should be modified to reflect congressional intent for the MLR calculation by eliminating any deductions of federal income or payroll taxes from the denominator.

Transparency of Information
Congress’s purpose in enacting MLR requirements in the Affordable Care Act was to ensure that “consumers receive value for their premium payments” (Section 2718(b)). To achieve this goal, consumers must have detailed and transparent information about how their premium dollars are spent. Transparency is particularly important for the accounting of Quality Improvement expenses, which both consumer groups and members of Congress fear will be vulnerable to gaming by insurers. Given the multitude of activities that insurers may count as QI, enforcing requirements for the proper accounting of QI expenses may stretch the capacity of many state insurance departments.

To reduce the risk of improper classification and accounting of expenses as QI costs, all forms in which insurers describe their QI spending, such as the “Detailed Description of Quality Improvement Expenses,” as included in the “Supplemental Health Care Exhibit’s Expense Allocation Report,” and any other supplemental filings detailing insurers’ QI expenditures must be available to the general public, not just to regulators. These forms should be available to the public in a timely manner and be posted online as well as available in hard copy from state insurance departments. Making these forms available will both allow consumer engagement and provide an additional incentive for insurers to comply with the QI accounting requirements of the MLR calculation.

Members of Congress have expressed concern that the MLR requirements in the Affordable Care Act, if not implemented properly, may not achieve their intended goal of holding insurers accountable for appropriate spending of consumers’ premium dollars. Therefore, we urge the

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NAIC to uphold the current Blanks Proposal by rejecting any requests to expand the definition of QI expenses. We also urge the NAIC to eliminate wellness incentives from the QI category and to modify the inclusion of federal taxes to match Congress’s intent. In order for the Affordable Care Act’s MLR requirements to have a meaningful impact in guaranteeing that consumers’ premiums are utilized fairly and reasonably by insurers, the QI and tax categories of the MLR calculation must be defined narrowly and insurer spending, particularly as it pertains to quality improvement costs, must be fully transparent to consumers.

Thank you for considering our comments. If you have any questions, please do not hesitate to contact Claire McAndrew at cmcandrew@familiesusa.org or at 202-628-3030.

Sincerely,

Claire McAndrew
Health Policy Analyst
Families USA

August 9, 2010

Commissioner Jane L. Cline
President
National Association of Insurance Commissioners
2301 McGee Street
Suite 800
Kansas City, MO 64108-2662

SENT VIA EMAIL TO: mailto:cavila@naic.org

RE: Section 2718 of the Public Health Service Act on Medical Loss Ratio Definition of Quality Improvement Expenses

Dear Commissioner Cline:

On behalf of our more than 170 member hospitals and 34 health systems, the Georgia Hospital Association is asking for your favorable consideration of the following recommendations at this week’s National Association of Insurance Commissioners (NAIC) Summer National Meeting. These recommendations relate to the implementation of the medical loss ratio provision of Section 2718 of the Public Health Service Act (PHSA).

As you know, Section 2718 of the PHSA imposes new minimum medical loss ratios (MLR) and reporting requirements on health insurers to ensure that a minimum percentage of insurance premiums are used to pay for health care services or activities that improve health care for enrollees. If an insurer fails to meet the minimum MLR, Section 2718 will require the insurer to provide an annual rebate to enrollees under such coverage.

The allocation of costs for MLR calculation should incorporate the following principles:

- Only payments to licensed professionals and entities that deliver health care services should be classified as health care services;

- Costs and expenses that are classified as activities that improve health care quality need to meet specific criteria that are clearly defined by MLR regulation; and

- Loss adjustment activities should be counted as administrative costs because they do not provide health care services or improve quality.

Georgia Hospital Association
1675 Terrell Mill Road, Marietta, Georgia 30067 • 770-249-4500 • Fax: 770-955-5801 • www.gha.org
Additionally, we recommend that health insurance plans be required to aggregate MLRs at a level that is meaningful enough to ensure compliance with the letter and spirit of the law. Aggregating MLRs at a company-wide level may be useful in examining solvency issues by regulators, but aggregating at too high a level might mask the variations in insurance markets and products.

Once again, we ask for your support of these critical recommendations as the NAIC finalizes their work on this provision of the PHSA. If you have any questions, please do not hesitate to contact me at jparkerg@aha.org or (770) 249-4522.

Sincerely,

Joe Parker
President

cc: American Hospital Association
August 10, 2010

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

RE: NAIC Executive Committee Health Reform Blank Proposal dated August 5, 2010

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

Via Electronic Mail

Dear Commissioner Cline, Members of the Executive Committee and Plenary Commissioners:

On behalf of the Consumer Representatives to the NAIC and consumer groups representing millions of patients, consumers and workers, we are pleased to have this opportunity to comment on the Executive Committee’s edits to the proposed Health Reform Blank drafted to implement the requirements of the Section 2718 of the Accountable Care Act. We appreciate the Executive Committee’s efforts to carefully and concisely refine the current Blank proposal to address a few remaining issues and concerns raised by individual commissioners and officials from the Department of Health and Human Services. While we can support most of these modifications to the Blank draft, we must raise specific concerns and reservations regarding the addition of public health marketing expenses, the current definition of fraud, the addition of prospective drug utilization review, and our continuing concern that the Supplemental filing will only be available to Regulators. We also believe that a change is needed with respect to federal taxes excluded from the denominator given recent clarification of congressional intent.

At the outset, we want to once again express our appreciation for the leadership provided by Mr. Felice and the Health Reform Solvency Impact (E) Subgroup and Commissioner Gross and the Financial Condition (E) Committee in successfully facilitating an open and inclusive dialogue amongst all parties throughout this lengthy process. Their professional expertise and personal credibility has been invaluable in navigating through very difficult technical issues and contentious differences of opinion during the Medical Loss Ratio (MLR) discussions. Mr. Felice and Commissioner Gross have been thoughtful and fair in considering the concerns and perspectives of all parties while remaining scrupulously attentive to the intent of Congress in formulating the methodology used to calculate the MLR.

General comments:
The current Health Reform Blank proposal provides an effective structure and format to establish clear instructions, concise definitions, and uniform standards for recording the various expenses in the MLR calculation. We believe it successfully reflects the intent of Congress in enacting Section 2718, which requires health plans to report on the proportion of premium dollars spent on clinical services, activities that improve health care quality, and all other non-claims costs, and to provide rebates to consumers if the amount of the premium spent on clinical services and activities that improve health care quality is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. As currently proposed, the Blank and instructions provide a technically sound approach to accounting for non-claim (administrative) costs, clinical services and activities to improve health care. It represents a conscientious effort on the part of the NAIC to craft solutions that remain consistent with the
intent of Congress and yet also sensitive to the need for practical definitions that can be
implemented in a timely fashion; not burden insurers excessively; and be understandable to
consumers, employers and other stakeholders. This has required compromise on the part of all
participants.

A primary goal of the MLR requirements is “helping consumers realize the full value of their
health insurance payments” to make coverage more affordable. Properly distinguishing clinical
improvement costs from non-clinical (administrative services) expenses is essential to realizing
this goal. While we prefer a narrower definition of fraud and inclusion of accreditation fees in
administrative expenses, we recognize and appreciate that the proposed Blank has included many
of our recommendations. Expenses related to fraud, controlling costs, discouraging excessive
utilization, making certain that providers are qualified, expanding claims processing to include
ICD-10 coding and other core competencies and best practices expected of any insurer are
appropriately defined as administrative activities/expenses. We are pleased that the Executive
Committee also recognizes that these activities belong in the definition of administrative services
consistent with section 2718. We oppose any changes to the proposed Blank that would allow
these expenses to be considered activities to improve health care quality and continue to urge the
Executive Committee to avoid reopening this debate by recommending any further changes that
would shift administrative expenses to the clinical or quality improvement components of the
MLR calculation. We also oppose any attempt to exclude broker’s commissions from the
formula, as they were recognized by Congress as a key administrative expense.

The Supplemental Health Care Exhibit Part 3 (Part 3) and in particular, the General Definition of
Health Care Quality expenses, are the product of many hours of intense discussion informed by
extensive written comments and open conversations with commissioners and all interested
parties. As proposed, Part 3 strikes a reasonable balance in assuring that health plans offer
evidence-based and objectively measurable quality improvement programs while not creating
unintended disincentives for insurers to reduce their investment in quality improvement
activities. Part 3 allows insurers to claim quality improvement activities that fall within the five
broad categories found in sections 2717 and 1311 of the Affordable Care Act: activities that
improve health outcomes, prevent re-hospitalization, improve patient safety and reduce medical
errors, and promote wellness and health, and certain HIT expenses. Part 3 also includes a
process insurers can use in the future to propose new quality improvement categories or
initiatives that do not fit within the five categories already found in the Blank. We support Part
3’s strong emphasis on measurable and objective criteria for improving the quality of care that
patients receive. We also support the inclusion of some flexibility to provide insurers incentives
to maintain current QI activities and continue to invest in innovative new quality initiatives. We
do, however, have specific comments to offer on Part 3.

Specific Comments:

- **ICD-10 Implementation Expenses:** We were pleased to note that the cost of the ICD-10
  conversion remains an administrative expense, where it properly belongs. The addition of
  Line 16 in Part 1 to track the ICD-10 expenses is a reasonable approach to addressing the
  concerns raised by insurers. As noted in our past comments, claims processing is a core
  competency of insurers and they are changing from ICD-9 to ICD-10 as part of a worldwide
  change in coding standards, one mandated of providers by CMS.
• General Definition of Improving Health Care Expenses: We support the modifications to the General Definition. The use of the terms “plan activities” is a more accurate description of the scope of quality improvement allowed in section 2718. We are concerned, however, with the blanket replacement of “associations” with “societies” and eliminating “or other nationally recognized health care organizations” as this may unintentionally exclude well-established entities involved with clinical guidelines and measuring health care quality such as the American Heart Association. The additional sentence regarding efforts to control or contain costs without diminishing quality is appropriate in light of the need to provide affordable health care. We endorse in particular the draft’s continued requirement that quality improvement efforts be evidence-based and objectively verifiable. This is essential if the process is to retain its integrity.

• Accreditation fees – We continue to oppose the inclusion of accreditation fees— as contrasted with expenses related to accreditation monitoring, measuring, and reporting—as a quality improvement expense. Accreditation addresses many insurer activities that are not health care quality improvement-related. Including the entire accreditation fee as a quality improvement expense, regardless of the extent to which the fee relates to quality improvement, is contrary to the intent of Congress that only quality improvement expenses be included in the numerator.

• Prospective prescription drug Utilization Review: We have consistently opposed the inclusion of prospective utilization review in quality improvement expenses from our earlier comments. We do not, however, oppose such the inclusion of prospective prescription drug utilization review for the purpose of identifying potential adverse drug interactions. The revised blank recognizes explicitly that some of the prospective utilization activities are not QI and that prospective utilization review programs must meet the criteria for improving health care (and must be accredited). This recognition is salutary. We are aware of the increase in over-prescribing and that adverse reactions from multiple prescriptions and abuses of certain medications should potentially be avoided or reduced through prospective prescription drug UR. We are concerned, however, that insurance regulators may find it difficult to distinguish between prospective drug utilization review programs directed at reducing potential drug reactions and other forms of prospective drug utilization review directed primarily at cost control. The blank is clearly not intended to permit insurers to classify all pharmacy benefit management expenses as quality improvement costs. We believe that this makes it all the more important that the schedule that insurers use to allocate expenses to quality improvement be publicly available rather than regulator only, so that public oversight of this allocation will be possible, as we note below.

• Wellness Incentives: We support the position of the current blank 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
• **Public health marketing campaigns:** While we recognize the value of well-designed state or local health and wellness campaigns and the important role that for profit and non-profit insurers have played in initiating, underwriting and supporting these health education activities, we firmly believe that the scope of what can be included must be clearly defined. We would recommend replacing “marketing” with “education” to more clearly communicate the intent that such campaigns must have as their primary purpose as education of the public in health and wellness. Similarly, these campaigns should be evidence-based and have clearly defined health outcomes that benefit the insurer’s enrollees. Public health marketing campaigns must be either directed toward individual enrollees of the insurer or otherwise reasonably expected to impact and benefit specified segments of enrollees. Further guidance and direction should be provided to assure that community benefit expenses deducted under line 1.6 not be double counted as public health education activities.

• **Provision of electronic health records and patient portals.** We support the inclusion of electronic health records and patient portals as quality improvement expenses. We believe electronic health records will play a key role in integrating care delivery, reducing adverse outcomes and duplication of services, facilitating continuity of care between providers and educating consumers about their own health status and self management of their care. Equally important are patient portals which will further engage and educate consumers enabling them to better understand their health insurance coverage, their role and responsibilities as patients, and their opportunities to improve their own health status by taking advantage of the resources that are available to them through the patient portal and other means.

• **Fraud Prevention – Need for a Definition –** 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 understand that the Committee has proposed alternatively that fraud detection and recovery expenses be deducted from fraud recoveries. We are concerned that the blank nowhere defines fraud detection and recovery expenses. We believe that insurers may attempt to classify all of their attempts at recovering erroneous overpayments, at rescinding insurance contracts, or at seeking repayment for excessive utilization as “fraud detection and recovery expenses.” We recommend that the NAIC adopt the definition of fraud used by Medicare to clarify the activities covered by this provision. “Fraud is legally a statement of a material fact made with intent to deceive by a person who knows the statement to be false, which is in turn relied on justifiably by the victim and results in actual injury.”

  [https://www.cms.gov/manuals/downloads/ge101c01.pdf](https://www.cms.gov/manuals/downloads/ge101c01.pdf), para. 20.3.1 Innocent misstatements are not fraud. The blank must include a definition of fraud detection and recovery that limits the covered activities to those addressing actual intentional fraud.

• **Supplemental Regulator only filing:** We urge the Executive Committee to assure that all information submitted by insurers to document MLR compliance and calculations be open to the public. The blank provides on page 18 for a supplemental, regulator-only, filing describing how an insurer calculates quality improvement expenses. The proposed revision of the blank calls for even more fine distinctions among expenses that may easily be
manipulated by insurers to move administrative costs to quality improvement expenses. A full public disclosure as to how they are making these distinctions is essential if the process is to have integrity. Public disclosure of all reporting relevant to the MLRs is also required by Section 2718(a), which requires that quality improvement expenses must be reported to HHS, which must make them public. We request that the Executive Committee assure that all information submitted by insurers to document MLR compliance and calculations be open to the public.

Finally, we also request a change to Part I of the blank. The NAIC has stated throughout the process of writing the blank that it was awaiting instructions on the intent of Congress with respect to the federal taxes that should be subtracted from the denominator. The definitions included in line 1.5 were included in default of clarification of this matter. The attached letter, signed by the chairs of each of the jurisdictional committees of the House and Senate that dealt with the ACA clarifies that the term “federal taxes” was not intended to include federal income and payroll taxes, but only the taxes imposed by ACA sections 9010, 6301, and 9001. This is consistent with the linking of federal taxes in section 2718(b) with licensing and regulatory fees and with premium revenues. We request that lines 1.5 and 10.3 be revised to reflect this clarification.

Congress appropriately delegated the responsibility to establish the definitions and methodologies for the MLR calculation to the NAIC – and the NAIC has succeeded in developing draft recommendations that remain true to the Congressional intent of section 2718. We urge the Executive Committee to reject any further modification to the Blank that would further weaken the MLR formula and upset the delicate and skillfully crafted balance. Constant re-visitation of the form and consideration of additional modifications runs the real risk of unraveling what we believe is a carefully woven fabric of consensus, compromise and common sense. As a result, we recommend that the Executive Committee move to final adoption of the proposed Blank without further delay.

On behalf of the NAIC Consumer Representatives, other consumer groups and all health insurance enrollees, we thank you for considering these comments.

Sincerely,

Timothy Jost
Mark Schoeberl
Bonnie Burns
Elizabeth Abbott
Stacey Pogue
Georgia Maheras

Barbara Yondorf
Wendell Potter
Brendan Bridgeland
Kim Calder
Congress of the United States
Washington, DC 20515

August 10, 2010

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

Section 2718 of the Public Health Service Act, as added by section 1001 and amended by section 10101 of the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148), requires health plans offering coverage in the group and individual markets to meet minimum medical loss ratio (MLR) standards as defined by the National Association of Insurance Commissioners (NAIC) and certified by you.

The MLR requirements are intended to ensure Americans receive the best value for their insurance premiums. In promoting this high-value coverage through MLR requirements, it is essential that the MLR calculation guidelines balance the need to preserve market stability.

As such, we commend the continued efforts of NAIC and your department to establish guidelines that protect families’ already-stretched budgets and ensure stable, competitive health insurance markets. It is important for you to set up a process to work with individual state insurance commissioners to ensure such balance during the transition to full health insurance reform in 2014.

As the NAIC works to craft proposed definitions, we are writing to clarify legislative intent as it pertains to the exclusion of Federal taxes from revenue calculations. Section 2718 sets forth the computation of MLR for purposes of computing annual premium rebates. Section 2718(b)(1)(A) defines the denominator of the MLR for this purpose as "the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees . . .)."

"Federal taxes and fees" in this context is meant to refer only to Federal taxes and fees that relate specifically to revenue derived from the provision of health insurance coverage that were included in the PPACA. Thus, the Federal taxes and fees that fall into this category are: (1) the annual fee imposed by section 9010 based on each health insurer’s market share based on net premiums written; (2) the annual fee imposed by section 6301 on each health insurance policy (based on the average number of people covered under the policy), and (3) the tax imposed by section 9001 on high-cost employer-sponsored health coverage. Federal income taxes or payroll taxes were not intended to be excluded from the denominator.
We hope this clarification is helpful and look forward to continuing to work together to ensure successful implementation of PPACA. Thank you for your attention to this important matter.

Sincerely,

Max Baucus
Chairman
U.S. Senate Committee on Finance

Sander Levin
Chairman
U.S. House of Representatives Committee on Ways and Means

Tom Harkin
Chairman
U.S. Senate Committee on Health, Education, Labor and Pensions

Henry A. Waxman
Chairman
U.S. House of Representatives Committee on Energy and Commerce

Christopher J. Dodd
Chairman
U.S. Senate Committee on Banking

George Miller
Chairman
U.S. House of Representatives Committee on Education and Labor

cc: Jane L. Cline, President, National Association of Insurance Commissioners (NAIC)
August 16, 2010

**Consumer Representatives**  
**Comments on Proposed Amendments to Financial Condition (E) Blank Proposal**

The Consumer Representatives to the NAIC, on behalf of millions of patients, consumers and workers, wish to convey our support of suggested amendments #1, 2, 3, 4, 6, 7, 8, 9, 10 and 11. For reasons we have stated in earlier comments, we cannot support amendment #5.

While in previous comments we expressed concern with amendments # 8 and 9, we now we understand that these amendments are intended to limit the extent to which wellness and health promotion activities and prospective utilization review can be claimed as quality improvement expenses. Without them, the definition will be much broader. Therefore, we urge you to support amendments #8 and 9.

We continue to have a concern that page 18 of the Blank indicates that the expense allocation supplemental filing is a “regulator only” form. The current definition of quality improvement will require many decisions by insurers as to whether activities should be classified as quality improvement or administrative and it is important that these decisions be transparent and open to the public. By adding new categories of quality improvement expenses, the suggested amendments make this even more important.

Tim Jost  
Georgia Maheras  
Wendell Potter  
Stacey Pogue  
Sabrina Corlette  
Butch Hollowell
August 11, 2010

Jane L. Cline
President, National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

RE: Medical Loss Ratios – Section 2718 of the Public Health Service Act (PHSA)

Dear Commissioner Cline:

The Pacific Business Group on Health (PBGH) is a business coalition of 50 large health care purchasers that seeks to improve the quality and availability of health care while moderating cost. We appreciate the opportunity to comment on the amendments to the Life and Health Blanks Proposal that was released last week. We focus our comments on the quality improvement activities, which include many of the elements that purchasers believe to be critical to improving patient care and affordability. Below, we provide suggestions on a few areas that can be strengthened:

- Require that the schedule insurers use to report their quality improvement activities be made public, facilitating greater transparency of investments in patient care.
- Make sure to include the proposed addition that qualifying quality improvement expenses “may have cost reducing or cost neutral benefits as long as the primary focus is to improve quality” (page 16). This addition is important to improve quality while advancing affordability of care.
- Do not remove “other nationally recognized health care quality organizations” from the inventory of entities that can serve as source of identified legitimate quality improvement activities (page 16). This proposed omission would bar National Quality Forum endorsed practices that have been passed through an important multi-stakeholder consensus process.
- Make unambiguous that provider performance measurement and public reporting activities on measures of clinical quality and patient experience are considered numerator activities. This clarification could be made in the Column 1 element “Quality reporting and documentation of care in a non-electronic format” (page 17).
- Clarify that the costs for reporting on patient experience are recognized along with those for clinical effectiveness with regards to Column 5: HIT Expenses for Health Care Quality Improvements (page 18). It appears that it is the intention of the document to include patient experience, but it is currently featured as an illustrative example.
- Provide clarification of why individual businesses are not being counted among those who can include the costs of “Actual rewards/incentives/bonuses/reductions in copays, etc.” in Column 4 (page 17).

On behalf of purchasers across the country, thank you for your efforts and your responsiveness to our comments. If you have any questions, please don’t hesitate to contact me.

Sincerely,

David Lansky, PhD
President & Chief Executive Officer
Pacific Business Group on Health
August 10, 2010

Jane L. Cline, President
National Association of Insurance Commissioners

Re: Medical Loss Ratios – Section 2718 of the Public Health Service Act

Dear Commissioner Cline,

URAC appreciates the ongoing time, energy and thought that the National Association of Insurance Commissioners (NAIC) has dedicated to its efforts to define and fully describe quality improvement (QI) activities for purposes of determining the calculation of the medical loss ratio under Section 2718 of the Public Service Health Act (PSHA). As the NAIC considers the Blanks Proposal at its Summer Meeting this month, URAC recommends two sets of technical changes to promote consistency in the document.

We commend the NAIC for further proposed changes to the Blanks Proposal that was approved by the Financial Condition (E) Committee last month. The proposed changes would remove accreditation fees from the excluded activities at the top of page 19 and include those fees as part of plan activities designed to improve health outcomes in Column 1 on page 16. We believe the inclusion of the accreditation fees is fully consistent with the other accreditation-related provisions approved by the E Committee, which recognize the central role that the accreditation process plays in providing health plans with independently established and verifiable health care quality standards and measures. As we noted in our June 15 letter to Lou Felice, Chairman of the NAIC’s Health Care Reform Solvency Impact Subgroup, including the accreditation fees, as proposed, will serve to bring them in line with all the other accreditation costs incurred by the plans to meet the quality standards established by the accreditation entities.

With respect to the Blanks Proposal to be considered by the Executive and Plenary Sessions this month, URAC requests that the NAIC adopt two sets of technical changes to conform the Supplemental Health Care Exhibit – Part 3 on page 4 (“the Exhibit”) to the definitional changes discussed above. Page 4 does include a proposed deletion of the ‘XXX’ under Column 1, but retains the X-outs for “1.5 Accreditation and Certification” in all of the other nine columns across the Exhibit. Importantly, the Exhibit also fails to delete the X-outs moving down the Exhibit for Small Group and Large Group coverage expenses under 2.5 and 3.5, respectfully. In our view, the proposed change to the QI definitions related to accreditation fees can only be carried out if the plan costs associated with the fees can be properly included in the Exhibit under all expense categories and for all three lines of coverage (individual, small group and large group). This can be accomplished by simply removing the X-outs pertaining to accreditation both across and down the entire Exhibit.

Thank you very much for the opportunity to offer these comments, as well as for NAIC’s efforts to carefully and accurately define the expenses properly associated with health care quality improvement activities in the calculation of the medical loss ratio under Sec. 2718 of the PSHA.

Sincerely,

Alan P. Spielman
President and CEO