



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 groups¹ 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

¹ American Heart Association, et. al., *Close the Loophole to Medical Underwriting in the Senate Health Care Reform Bill (Letter to Members of Congress)* (Washington: American Heart Association, December 21, 2009) available online at <http://www.aucd.org/docs/HIPAA%20wellness%20Sign-On%2012-18-09%20%28FINAL%29.pdf>.

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).

2 For example, see the “Benicomp Advantage Plan,” http://www.benicompadvantage.com/products/faq_employers.htm, as cited in Karen Pollitz, *Wellness and Nondiscrimination: Two Important Issues Intersect (Presentation for the Alliance for Health Reform)* (Washington: Georgetown University Health Policy Institute, December 7, 2009) available online at <http://www.allhealth.org/briefingmaterials/Pollitzpresentation-1681.pdf>.

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.starnewsonline.com/article/20090920/ARTICLES/909209993?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.*

4 See Department of the Treasury, Department of Labor, Department of Health and Human Services “Nondiscrimination and Wellness Programs in Health Coverage in the Group Market; Final Rules,” *Federal Register*, Vol. 71, No. 239, December 13, 2006.

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.⁵ 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.⁶ 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.⁷ Therefore, we urge the

⁵ Senator Max Baucus, Senator Sander Levin, et. al. *Letter to Secretary Kathleen Sebelius* (Washington: United States Congress, August 10, 2010).

⁶ Senator Al Franken, Congressman John Wu, et. al. *Letter to Commissioner Jane L. Cline* (Washington: United States Congress, August 3, 2010).

⁷ Senator Al Franken, Congressman John Wu, et. al. *Letter to Commissioner Jane L. Cline* (Washington: United States Congress, August 3,

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

2010); United States Senate Committee on Commerce, Science, and Transportation, *Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers*, (Washington: Committee on Commerce, Science, and Transportation, April 14, 2010); Congressman John F. Tierney, et al., *Letter to Secretary Kathleen Sebelius* (Washington: United States House of Representatives, April 26, 2010); Congressman John D. Rockefeller, *Letter to Secretary Kathleen Sebelius* (Washington: United States Senate, May 7, 2010).