

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 as such the inclusion of prospective prescription drug utilization review for the purpose of identifying potential adverse drug interactions. The revised blank recognizes explicitly that 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>, 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.

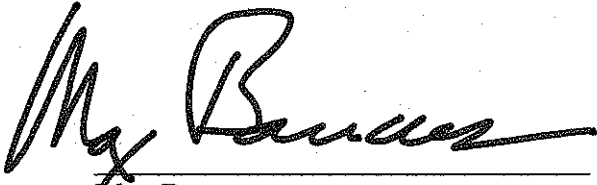
As such, we commend the continued efforts of NAIC and your department to establish guidelines that protect families' already-stretched budgets and ensure stable, competitive health insurance markets. It is important for you to set up a process to work with individual state insurance commissioners to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

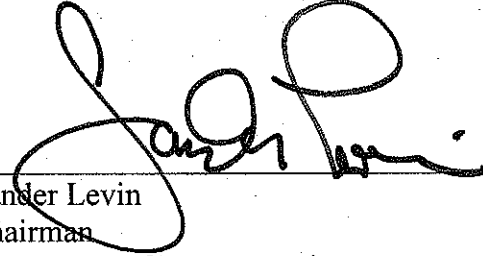
"Federal taxes and fees" in this context is meant to refer only to Federal taxes and fees that relate specifically to revenue derived from the provision of health insurance coverage that were included in the PPACA. Thus, the Federal taxes and fees that fall into this category are: (1) the annual fee 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,



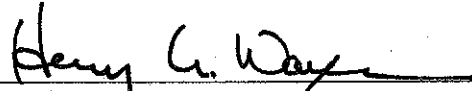
Max Baucus
Chairman
U.S. Senate Committee on Finance



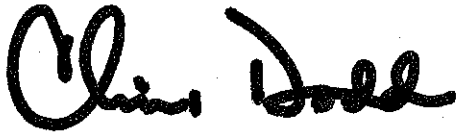
Sander Levin
Chairman
U.S. House of Representatives
Committee on Ways and Means



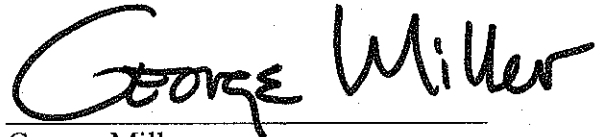
Tom Harkin
Chairman
U.S. Senate Committee on
Health, Education, Labor and Pensions



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)