American Association of Preferred Provider Organizations

May 17, 2010
VIA EMAIL tsells@naic.org

Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup

Steven Ostlund
Chair, Accident & Health Working Group

RE: Categorization of Network Access Fees as Expenses for Health Improvements

Dear Mr. Felice and Mr. Ostlund:

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 — greater access, more choice and flexibility — that PPOs bring to over 199 million Americans covered by PPOs today. Sixty nine percent of all Americans having health care coverage today are covered by PPOs.

It is vital that the health improvement aspects of network development and management are recognized as part of medical loss ratios. The percentage of network fees that can be documented and verified by insurers pertaining to network quality standards with respect to accreditation standards, state network adequacy requirements, medical/case management and specialty provider standards should be considered as expenses improving health care quality in any medical loss ratio.

The majority of PPO networks are non-risk, that is, they do not assume the financial risk for an enrollee’s medical costs. The network’s primary focus is to contract with providers in a geographical area to form an interconnected, efficient, and quality network of providers and services that are marketed to payers, insurers and Third Party Administrators (TPAs).

Network development is very costly because of the quality components that are inherent to the process. Therefore, many insurers especially mid size insurers, self-insured employers, union trusts, third-party administrators, business coalitions and associations make the decision to “lease/rent” networks to ensure they can offer quality networks as the platform for their benefit programs that meet all the same quality standards that would be part of network owned by an insurer, in fact depending on the insurer and their specific network requirements, “leasing/renting” a network may prove to be more cost effective than developing or owning their own network. While “leasing/renting” a network may be viewed as a cost containment measure it is also very important to recognize that a portion of any network access fee represents the cost...
associated with ensuring network quality standards are met. Networks that are “leased/rented” must meet accreditation quality standards that measure network adequacy standards, specialty provider standards, medical/case management criteria and credentialing and appeal standards. These quality standards in many states are required by law. Whether mandated by state law or through URAC or NCQA accreditation, networks must establish and maintain quality management programs to improve the delivery of healthcare services.

Finally, most non-risk PPO networks are long-established businesses serving a local community, state, or region. This allows each of them to understand the unique needs of their geographic area – and make certain much needed quality treatment options are available. Non-risk PPO networks also allow insurers to offer coverage in rural communities with so few covered lives that building a dedicated network would not be feasible. In short, non-risk PPO networks offer quality solutions for meeting statutory requirements and provide seamless coverage to consumers, whatever their needs, wherever they need service.

I appreciate your consideration of our comments and 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 J. Greenrose.
President and CEO
Expenses, other than those billed or allocated by a provider for care delivery (i.e. claims costs), that are designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care in ways that can be objectively measured and verified. The following are items that will included as quality of care expenses meeting these criteria:

1. **Care coordination** (not just general care management) - the active hands on participation to coordinate a patient’s care between multiple providers (such as making sure medical records are shared between all the patient's physicians, making/verifying appointments, and medication compliance) and arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center and prevention of hospital readmissions).

2. **Chronic Disease Management** Hands on individually tailored programs for specific chronic conditions that interact with the insured (in person or via the phone) to (a) remind insured of doctor appointment, (b) check that insured is following a medically effective prescribed regimen for dealing with the specific disease/condition, (c) incorporating feedback from insured in the management program, (d) provide coaching on dealing with the disease/condition.

3. **Preventive Care and Wellness Programs**: Hands on programs that interact with the insured (in person or via phone) related to: Wellness assessment, wellness / lifestyle coaching programs, coaching programs designed to educate individual members on clinically effective for dealing with a specific chronic disease, and coaching or education programs designed to change individual members behavior (e.g. smoking, obesity).

4. **Network access fees to Preferred Provider Organizations and other network-based health plans engaged in maintaining network adequacy, network accreditation, provider credentialing, medical/case management, or specialty provider standards**

5. **Other costs** approved by the Secretary, in consultation with the NAIC, which in her discretion, upon an adequate showing that the costs improve the quality of healthcare; the burden shall be on the proponent to show that the costs improve the quality of healthcare.

E.g., 24 Hour Nurse Hotlines: Expenses for 24 hour nurse hotlines should be included in care coordination, chronic disease management, and preventive care and wellness programs to the extent they meet those expense requirements. Any other expenses for 24 hour nurse hotlines should be excluded from Improving Health Care Quality Expenses and instead included in Claims Adjustment Expenses.

The following items are broadly excluded as not meeting this criteria:
- Utilization Review
- Fraud Prevention activities
- Any function not expressly included in Type A items 1 through 4, above.
Expenses for Health Information Technology (HIT), consistent with the purposes described in A, above, defined as depreciation on hardware and expenses for software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for use by health plans, health care providers, or patients for the electronic creation, maintenance, access, or exchange of health information and the personnel costs associated with implementing those technologies or licenses, but limited to the following expenses:

1. Monitoring or reporting clinical effectiveness;
2. Advancing the ability of providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently;
3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;
4. Other costs approved by the Secretary, in consultation with the NAIC, which in her discretion, upon an adequate showing that the costs improve the quality of healthcare; the burden shall be on the proponent to show that the costs improve the quality of healthcare.

Line 7.1 – Cost Containment Expenses not Included in Quality of Care Expenses in Line 5.4

Include: Expenses that actually serve to reduce the number of health services provided or the cost of such services. Exclude cost containment expenses which improve the quality of health care reported in line 5.4. The following are examples of items that shall be considered “cost containment expenses” only if they result in reduced levels of costs or services:

- Post and concurrent claim case management activities associated with past or ongoing specific care;
- Utilization review;
- Detection and prevention of payment for fraudulent requests for reimbursement;
- Expenses for internal and external appeals processes.
- Network access fees to Preferred Provider Organizations and other network-based health plans (including prescription drug networks), and allocated internal salaries and related costs associated with network development and/or provider contracting.
Copy of Emailed Comments
May 24, 2010

Dear Mr. Felice and Mr. Sells: The Alliance of Community Health Plans – whose members are non-profit health plans or health plans that are subsidiaries of non-profit systems – has previously commented on the NAIC draft Exhibit and Instructions for calculation of MLR in a letter submitted on May 10 and email dated May 14. We appreciate the time and effort that you and your colleagues continue to devote to this effort and the ongoing process of consultation with interested parties. We submit the following additional comments on the draft circulated on May 20. In case formatting gets lost in the email transmission, a copy of our comments is attached as a pdf.

Line 1.6 – State and Local Insurance Taxes and Assessments

We believe the last line in the instructions (on p. 7) which currently reads “State income taxes other than premium taxes” should be modified as follows:

State and local income, excise, and business taxes other than premium taxes.”

State and local jurisdictions may impose excise and business taxes on gross receipts from engaging in business activities within the jurisdiction, separate from income taxes.

Line 1.7 – State and Local Premium Taxes (Community Benefit Expenditures)

We urge reconsideration of the language in the instructions, which currently reads: “Payments for community based expenditures in lieu of premium tax but limited to the state premium tax rate.” (bottom of p. 7)

We appreciate that NAIC has recognized that community benefit expenditures should be subtracted from premium revenues in the denominator, akin to how federal and state taxes are deducted for for-profit insurers. These community benefit expenditures reflect federal requirements for tax-exempt health plans. Because this is an issue that uniquely affects tax-exempt plans, many of which are ACHP members, we are developing language that we hope to submit to you soon – but beyond noon CDT on May 24 – and we request your consideration of our language which we will submit as soon as possible. We would make two points at this time:

• First, while tax-exempt organizations are required to provide community benefits, there is not a one-to-one ratio to the amount of taxes that they would have paid if they were for-profit plans. Thus, we do not believe the following language in the instructions for Line 1.7 is correctly stated: “Payments for community based expenditures in lieu of premium tax but limited to the state premium tax rate.” All community benefit expenditures reported on the IRS Form 990 by tax-exempt organizations should be included as a subtraction in the denominator.

• Second, because community benefit expenditures derive from federal tax law, we believe that the subtraction for community benefit more properly belongs in the instructions for Line 1.5 rather than Line 1.7.

To reiterate, we will forward more specific language to you as soon as possible and request that you consider our recommended language in preparing the next draft.

Line 3 – Incurred Medical Incentive Pools and Bonuses

The instructions (bottom of p. 10) currently read: “Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to share savings or promote quality improvements as defined in the PPASA [section....]”
We appreciate your recognition of a point made in ACHP’s earlier comments, that not all incentive bonuses involve shared savings arrangements. For example, many health plans provide quality bonuses to providers based on improvements in HEDIS scores. We believe the current language may still tie these payments to risk sharing arrangements and that the following language would be clearer:

Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to share savings or make incentive payments to providers to promote quality improvements as defined in the PPACA Section 2717.

**Line 5 – Expenses for Health Care Quality Improvements**

We know that NAIC continues to work on this difficult section. We offer the following comments for your consideration:

- At least two activities mentioned in PPACA Section 2717 are not included in the bulleted list of activities that improve quality and we believe they should be included as well: quality reporting and use of the medical homes model.
- The relationship between the bulleted activities and the four categories of activities is not clear. The draft uses the phrase “These activities are embedded in the following 4 categories...” but it would seem that it would be better to have one list of permitted activities rather than two.
- We continue to believe that the introductory paragraph for Line 5 sets a difficult threshold for quality activities. The phrase “in ways that can be objectively measured and verified” is both unnecessary to this paragraph and contradictory of the test in the last of the four categories of quality improvement activities. The phrase is unnecessary because this paragraph is simply introductory about the types of activities that improve the quality of care. And it is contradictory of the language in category 4 which requires an “adequate showing” and places on the proponent the burden of showing the Secretary that the costs improve quality. We agree that the burden should be on the proponent, just as the burden is on the entity submitting an annual statement to support all of the expenses listed in the statement. Entities listing quality-related expenses should be required to make a reasonable case that the activities improve quality, but “objectively measured and verified” seems to imply a scientific test that cannot yet be supported by the state of the art of health care quality improvement and could well inhibit innovative efforts to improve quality. Thus, our recommendation for the introductory paragraph would be:

  Expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), that are designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care, in ways that can be objectively measured and verified.

  Alternately, we would suggest:

  Expenses, other than those billed or allocated by a provider for care delivery (i.e. claims costs), that are designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care, in ways that can be objectively measured and verified. The burden shall be on the proponent to show that these expenses improve the quality of health care.

- We have commented previously on the importance of accreditation, and encourage you to explicitly recognize in the list of activities that improve health care quality both the direct costs of seeking accreditation from a recognized accrediting agency as well as the costs of achieving the required standards.

**Line 5.2 – HIT Expenses for Health Care Quality Improvements**

The NCQA representative raised the question on last week’s conference call about the non-IT costs of collecting and reporting on quality measures, especially the costly function of manual chart review and
patient surveys. ACHP agrees with this position, as we indicated in earlier comments submitted. It appeared from comments made by Mr. Felice and others that these expenses would be included on Line 5.2, but we recommend making this explicit, perhaps with the following addition to item #1 in these instructions:

1. Monitoring, measuring, or reporting clinical effectiveness, including chart review and other manual processes to derive information that is reported;

An alternate way of handling this might be to change the title of Line 5.2 to:

Data Collection and HIT Expenses for Health Care Quality Improvements

Thank you very much for your consideration of these recommendations. Please let me know if you have any questions or require additional information.

Howard Shapiro | Director, Public Policy | Alliance of Community Health Plans
Ph: 202-785-2247 | Fax: 202-785-4060 | Email: hshapiro@achp.org
May 20, 2010

Mr. Steve Ostlund
Chair, Accident & Health Working Group

RE: Preliminary Issue Identification Memo for PPACA Subgroup

Dear Steve:

I write today on behalf of America’s Health Insurance Plans (AHIP) to provide the PPACA Subgroup of the Accident & Health Working Group with input and comments on your Preliminary Issue Identification draft distributed on Friday, May 14, 2010. We appreciate, given the short time frames, your willingness to share these preliminary comments. Our comments below are similar to the comments I made on your Subgroup’s call on Monday, May 17, 2010. AHIP is the nation’s trade association representing nearly 1,300 member companies providing health, long-term care, dental, disability and supplemental coverages to more than 200 million Americans. We appreciate the opportunity to provide comments on this important project. AHIP is committed to the development and maintenance of a strong regulatory regime to oversee United States insurers, particularly those in the health sector.

We have in general recommended a state-based approach to aggregation under which a loss ratio would be calculated for each insurance holding company group in each of the three market segments, with the particular challenges of large employers taken into account.1 Since later portions of the document note that you are “exploring other options…such as interstate pooling” we wish to suggest that the proposed definitions be flexible in dealing with aggregation. We wish to highlight the following portion of our initial comments to the NAIC:

A flexible process for aggregation should be developed to (i) insure that the credibility standard is reached as quickly as possible for all policyholders so that valid rebates are paid and not deferred, (ii) reduce the potential for paying rebates based solely on statistical fluctuations in year-by-year experience, (iii) allow the use of appropriate risk management within carriers and companies so that risk margins do not need to be increased to reflect greater solvency risk from excessive rebates over a number of years and (iv) allow carriers and companies to coordinate the development of premiums and reasonable premium increases based on their

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1 We note that the draft does not address the determination of “state.” The exposed Supplement uses “situs of contract” which we believe is the correct basis for determination. The AHWG may wish to either note that they are not addressing this issue as outside their charge or that they support the Supplement instructions.
accumulating experience in a manner as close as possible to the experience reported for section 2718 reporting.

Such flexibility should be premised on the increased credibility of the results and the consistency of the rating when several states are being pooled. The regulations should spell out the manner in which such multi-state pooling would be subject to change over time. This is critical in that rebate calculations starting in 2014 will be based on loss ratios over a three year period. We stand ready to assist in any such development.

We appreciate the willingness of your subgroup to address the issue of large claims as part of a pooling mechanism. We are concerned that an approach that applies only within a legal entity is too narrow. Subject to sufficient regulatory control, the proposed pooling could be expanded to include stop-loss reinsurance or pooling with affiliates - properly structured with a similar specified maximum amount that must remain within each of the state-individual/small group/large group segments for reporting purposes.

Given that your group has not addressed QI issues, we will not deal with those in this response.

We agree that the reporting of rebates in financial statements must be done in a manner that allows regulators to assess both the amounts of rebates paid for prior periods, the adequacy of any liability established for potential rebates for the current year and the impact of rebates on the solvency of the company. Rebates paid for prior years within the three year period must be properly recognized in the current year calculation. The placement of rebate payments and liability amounts may very well be different for the Supplemental Health Care Exhibit and for the ‘normal’ pages of the financial statements. For example, one of our proposed changes to the Supplemental Exhibit is to move the amount of rebates paid to below the operating and net income lines. This allows the regulator to look at the operating results for the current year without them being distorted by the rebates paid for the prior year. Showing the rebate amount below the net income will allow the regulator to determine the degree to which the combination is reducing capital and surplus.

Your description of Incurred Claims is consistent with our understanding of what should be included. We would observe that the contract reserves in the Supplement should not be tied to those used in the Annual Statement. The MLRs are not designed to address the pattern of durational loss ratios that results from the sales of many individual market policies. The addition of contract reserves based on a one year or two year full preliminary term reserve basis which give relief for expenses during the first year does not match the pattern either. The use of a net level reserve basis for contract reserves for the Supplemental Exhibit would allow proper matching of revenues and expenses. We ask that the final definition clearly provide for the option to use a net level contract reserve for use in the Supplemental Exhibit.

The draft does not comment on Premium Deficiency Reserves. While these may be necessary for the annual statement and could be reported within the Supplemental Exhibit, they should be “below the lines” used for purposes of MLR calculation. Any liability for current year rebates should also be below the line so they do not impact the MLR. Reserves for future contingent benefits, however, should be designated as appropriate reserves for
inclusion within the determination of incurred claims – i.e. above the line - as they relate to likely claims based on current coverage.

We support the continued use of the Academy of Actuaries to develop an appropriate scale of tolerance values to address the potential lack of credibility in the results of small plans. We note that these factors could be different for each of the individual, small group and large group lines to recognize the different levels of benefits and deductibles commonly used in each line.

We note the comments in the last paragraph under Credibility and Pooling. Appropriate credibility and pooling mechanisms can help address concerns regarding limited aggregation. However, there are other factors to consider as well. The process for calculation of rebates should address durational issues and other factors related to the current market environment that impact the design of coverage today and that are not expected to change until 2014. Not addressing these issues threatens stability in the market and access to coverage options. In this regard, we would like your subgroup to consider transition rules along the lines we describe in the attachment or other methods to address the issues we have discussed above and in our transition discussion.

We support your description of the elements of the denominator.

With respect to the calculation procedures, we support the use of the calendar year as the basis of reporting. We believe that when you develop the rebate calculation that it should be due later than March 31⁴. Additional time will reduce the impact of estimates to both earned premiums (especially for large groups) and incurred claims. The determination of which claims meet the requirement for pooling, because they exceed the maximum specified amount, will not be easy using the suggested reporting date. To the extent a rebate is paid, we support payment to policyholders.

We believe that the rebate calculation should ignore the results for any policy that does not have a full twelve months of experience at the end of the calendar year. This approach is used in the Medicare Supplement Refund calculation to recognize that claims occur on average latter in any year than earned premiums which are more equally distributed. This could be added to the calculation procedures as they are more fully developed.

We thank you for the opportunity to provide comments. We anticipate providing further comments on outstanding issues such as smaller plans, different types of plans and newer plans. If you have any questions or comments please feel free to contact me at (623) 780.0260 or at omegasquared@msn.com.

Sincerely,

Bill Weller

c/c: John Engelhardt, NAIC Staff
      Randi Reichel, AHIP
      Shari Westerfield, BCBSA
Special Considerations for Transition and Newer Plans

A large portion of the in force policies in the individual market have been designed to comply with the existing state-based MLR requirements on a lifetime loss ratio basis. These policies will continue to be issued in order to provide individuals and families access to coverage for most of 2010 as the final PPACA regulations are being developed. Once those regulations are finalized, there will be a potentially significant delay while carriers file new rates. Most policies using updated rates will not be sold until sometime during 2011.

In addition, a large portion of the in force policies in the individual market will continue, until 2014, to show a pattern of increasing durational loss ratios and, to ensure stability in the market, will need to be priced based on a lifetime loss ratio. Prior to the full implementation of the insurance exchanges in 2014, many individuals and small businesses will continue to rely on the current distribution systems to find the policies that best meet their individual needs. If the MLR calculations used until 2014 do not take into account the durational loss ratio patterns that exist in the individual market today and will continue through 2014, many health plans may not be able to continue offering coverage in the individual and small group markets prior to 2014 - resulting in fewer coverage options for consumers.

Thus, during the transition period from 2011 until 2014, there should be specified approaches for states to adopt that, as PPACA requires, take into account the special circumstances for smaller plans (e.g., credibility adjustment), different types of plans (e.g., transition from current lifetime loss ratios to PPACA MLRs) and newer plans (e.g., first year business and individual products with durational loss ratios).

For example, States could be provided with rebate calculation rules that allow for transition from the existing state’s lifetime loss ratio (used for 2011) to the State’s PPACA MLR for 2014 with equal steps in 2012 and 2013. Since claims experience for individual and small group increases as the duration of each policy increases, the transition rules could also allow for the use of duration adjustments to the State’s lifetime loss ratio.

In addition, amounts from policies in their earliest years would be “reserved” until the block has matured to a seasoned level where annual MLRs could be applied. To the extent that the use of net level contract reserves does not fully recognize this, a separate reserve within the rebate calculation could be developed. Existing policies have higher costs in the first year already embedded in them, and the claims experience has not had sufficient time to develop. We are concerned that many products available in the market that will have a durational loss ratio pattern may no longer be viable in the transition years without a similar reserving, creating significant stability and access to coverage issues for consumers.
May 24, 2010

Mr. Lou Felice
Chair, Health Reform Solvency Impact (E) Subgroup
C/- New York Department of Insurance
25 Beaver Street
New York, New York 10004-2319

RE: Health Reform Blanks Proposal – May 20 Exposure Draft

Dear Mr. Felice:

We write today on behalf of America’s Health Insurance Plans (AHIP) to provide the Health Reform Solvency Impact (E) Subgroup with input and comments on the Subgroup’s new exposure of a Blanks proposal relating to the reporting of Medical Loss Ratio information pursuant to sections 1001 and 10101 of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (PPACA), (Pub. L. 111-148) (referred hereafter as PPACA Section 2718 for ease of reference). AHIP is the nation’s trade association representing nearly 1,300 member companies providing health, long-term care, dental, disability and supplemental coverages to more than 200 million Americans. We appreciate the opportunity to provide comments on this important project. AHIP is committed to the development and maintenance of a strong regulatory structure to oversee United States insurers, particularly those in the health sector.

PPACA Section 2718 tasks the NAIC with developing uniform definitions of the activities reported under 2718(a), as well as the standardized methodologies for calculating “measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2) (of Section 2718).” It is our understanding that the most time critical elements of the exposed form are the Parts 1, 2 and 3 and that the Instructions will involve further joint efforts involving the AHWG PPACA Subgroup with your subgroup. We will, therefore, focus on the lines and columns while addressing some comments on the Instructions. We also believe that this Supplement is not meant for the calculation of rebates, only the Statutory recognition of payments and liabilities relating to rebates. If this is incorrect, we would add significant comments with respect to the manner in which rebates are calculated from the information to be reported in this Supplement.

Proposal Form

1. **File annually.** We do not believe that this Supplement needs to be filed on a quarterly basis. The expanded reporting segmentation in this Supplement is not consistent with the reporting in the normal quarterly blanks and so will require the allocation of innumerable values in the quarterly statement without the amount of time companies expend to complete the more involved annual statement. For solvency purposes, we
believe that the reporting, without separating by line of business, of certain key expense components should be sufficient for regulators to make any actionable determination of solvency concerns. The loss ratio results for the quarterly statement (on a state-by-state basis) would be of little value for solvency and would be of no value with respect to the reporting of MLRs. The impact of rate increases, annual deductible and seasonal variations means that MLRs will vary by quarter even if the amount of business could be credible on a quarterly basis.

2. Anticipated Effective Date. We recognize the technical complexity associated with this Supplement, and recognize its significance starting with MLR reporting for calendar year 2011. There may be merit in a test filing of the Supplement for 2010, using grand totals, due by July 31, 2011 (consistent with our recommendation 3 below, and the proposed June 30 run-out date in the draft from the AHWG PPACA Subgroup) so that both carriers and regulators can learn from the work involved.

3. Supplement Due Date. We believe that this Supplement should be filed at the same time as the rebate calculation form (still to be developed) is due. This will avoid having multiple MLR values based on different periods for tracking incurred claims through to the actual payment. We believe that the comparison of details behind the MLRs that will be reported and the values behind the rebates need to be consistent. We do not believe that there is the same need to maintain consistency to the values reported in the Annual Statement.

Supplemental Health Care Exhibit – Parts 1 and 2

1. With respect to the General Instructions and Column Instructions section, we are not convinced that the Supplement values will be able to be directly related to the Statutory Annual financial statements. As an example, we note that, within a state-based approach, the AHWG PPACA Subgroup is looking into allowing for ‘pooling’ across lines and states and possibly outside the legal entity as appropriate ways to reduce the volatility of annual MLRs. In addition, the treatment of association business in the Supplement is not consistent with the Annual Statement. Similar to the reconciliation of Statutory to GAAP financials, it may be more appropriate to start with a generalized requirement to reconcile in an attachment which focuses on the Supplement’s Grand Total parts and the Annual Statement. This would mean that many of the lines in the Supplement could be removed (especially on the state portions) and regulators could review the methods carriers use to reconcile. At some later date, based on the early experience, a standard reconciliation approach could be developed if it was determined that such was necessary.

2. The third sentence in the second paragraph of these instructions should read “The allocation of premium and claims between jurisdictions” – so that claims are connect to the premiums.
3. We do not believe that this Supplement should redefine the "situs of the contract". At a minimum, better wording would be:
   For individual business sold through an association, allocation shall be based on the issue state of the certificate of coverage. For small employer business issued through a group trust, allocation shall be based on the location of the small employer.

4. Similarly, the paragraph dealing with packages provided to group employers may work where this is not a significant portion of a legal entity's large group line. Many large groups will have a diverse population across many geographic areas yet utilize a common per employee premiums scale. Differences in reimbursement rates, frequency of use of various medical protocols vary greatly across the country. Requiring the reporting of these average premiums for each legal entity is likely to result in the improper allocation of premiums in relation to claims. It may be possible that the AHWG PPACA Subgroup will provide for pooling within their work. If not, we will need to revisit this issue in the further development of instructions.

5. We support the revision reflecting Uninsured Plans as a column and not lines. We recommend that the term "Uninsured Plans" be used throughout replacing "self-insured" where that term is used.

6. We believe that the statement with respect to policies to be included in Small Group Employers should include an additional sentence: The reporting of experience for groups above the state's Small Employer Groups maximum number of employees is for purposes of this Supplement only and does not revise state laws applicable only to Small Employers as defined in such laws.

Supplemental Health Care Exhibit – Part I

7. With respect to the Earned Premium section, we continue to express a desire to allow for some stop-loss reinsurance and/or pooling to reduce the volatility of MLRs in each of the columns for each state. Wide ranging MLR values based on where the highest claims occur in any one year are not representative of any meaningful statistic.

For lines 1.5 through 1.8 we recommend clarifying whether it is anticipated that reporting will be necessary beyond columns 1, 2, 3, and 9. That appears to be the assumption in the instructions, but there are no "XXXs" in the remaining columns, nor is the 'Exclude' language clear. There does not appear any authority in PPACA for the exclusions for lines 1.5 and 1.6.

The instruction for line 1.7 should read: State and Local premium taxes plus state taxes based on policy reserves, if in lieu of premium taxes. We do not believe the last sentence is appropriate for this line. The next paragraph should be limited to the "state premium tax rate times the allocated premium amount." With respect to line 1.8, it should include
expenses for regulatory bodies that serve in lieu of the insurance department. We do not see the basis for excluding fees for normal examinations. Finally, we support the addition of line 1.12 and its instructions.

8. With respect to the section on Incurred Claims, it would appear that the instructions for line 2.1 of Part 1 should be separately describing the development of the various portions of Part 2 so that the changes in reserve amounts do not get double counted. The description of the various sub-parts of incurred claims should apply to lines 2.1 through 2.10, except as noted below with respect to line 2.8. Then the Include/Exclude would focus on specific lines in the second section of Part 2.

9. Rebates (line 4.3) – We recommend, as in our earlier proposed changes, that rebates paid during the year as well as information on rebate liabilities be added as lines below the net gain or (loss) line. This allows the net gain or (loss) to relate to the current year unaffected by rebates. This is important for both the solvency aspects of regulatory review but also so the Supplement can be useful to regulators involved in the rate review aspects of PPACA.

10. Incurred Medical Incentive Pools and Bonuses (line 3) should be “From page X” and Part 2 lines 2.8 should be separated into and third subsection using lines 2.8a through 2.8c as lines 3.1 through 3.3 to produce a line 3.4.

11. Medical Loss Ratio (line 6) – We do not believe that the reported results will provide a credible value in many situations, and may instead reflect significant volatility. As we proposed in our prior comments, we recommend that this section add lines to reflect adjustments due to the lack of credibility from random variability in incurred claims (the impact of “smaller plans”). Consistent with the statute’s requirement to consider “special circumstances”, we believe another line should be included to reflect adjustments for “newer plans” and “different types of plans” that would deal with policies that were not priced to an annual loss ratio standard, nor set at PPACA levels, and which should be given time to allow re-pricing to take effect. This will be particularly important during the transition to 2014.

We note also that PPACA requires the carrier to report their MLR include all loss adjustment expenses in the numerator – section 2718(a), in the first sentence.

12. Expenses (lines 7 and 9) – We suggest that the following language be added to these lines to insure that expenses are not included in two or more places and that line 7.1 can be just “Cost containment expenses”:
   For Line 7: Claim Adjustment Expenses not included as expenses in line 5.4
   For Line 9: General and Administrative (G&A) Expenses not included in line 5.4 or line 7.3
13. **Other Indicators** – We recommend that you add a sentence prior to Line 1 which would read: “These should be allocated to jurisdictions in the same manner as premium.”

**Supplemental Health Care Exhibit – Part 2**

14. We recommend that the columns for Part 2 match the first seven columns from Part 1.

15. As noted above, we would recommend that there be a separate subsection to deal with Incurred Medical Incentive Pools and Bonuses only because they generate a separate line in Part 1 (line 3).

16. As noted above, certain items that only appear in Part 2, because they feed into the calculation of earned premium and incurred claims are described in the instructions for Part 1. We believe this has the potential to be confusing, and in order to provide greater clarity recommend providing instructions in the Part where a particular term is used. For example, “Change in Contract Reserves” no longer appears in Part 1 while the beginning and ending values of “Direct Contract Reserves” are lines in Part 2 but also would be reported within line 2 as the instructions currently read. As we have proposed in our previous comments, the contract reserve amounts for this Supplement could possibly be on a different basis than what is reported for in the main blank.

**Instructions Regarding Expenses for Health Quality Improvements page 11 (should move to the instructions related to Supplemental Health Care Exhibit – Part 3)**

17. We appreciate the changes in the May 20th Draft Exposure that added additional details regarding health care quality expenses. In order to ensure that key quality initiatives are supported, we urge consideration of the following additional points:

- **Care coordination**: The language “direct interaction between the insurer and the enrollee” to coordinate care is unnecessarily limiting. There are cases where the insurer interacts directly with providers to coordinate care, and the providers communicate directly with the enrollee/patient. This is especially true when the enrollee is an inpatient at the time, and the coordination is for transition of care - or to rehab units, etc. Thus we recommend the deletion of that language, beginning the paragraph (after the parentheses) “to coordinate a patient’s care...”

- **Acute Care case management**: many activities of Care coordination are related to acute care situations, such as helping assure quality care and coordination with joint replacement surgery, at-risk pregnancy management, transplants, etc. We urge the inclusion of language referencing “including acute care” in the first category of quality initiatives.
- **Nurse hotlines**: Many of the calls to nurse help-lines are related to emerging acute care issues, or to obtain assistance in coordinating an episode of treatment. Nurse help-line calls are also valuable decision support tools that enrollees use in managing their own care. That either needs to be explicitly added to the three grouping categories, or the exclusion of nurse hotlines needs to be removed, as still too limiting.

- **Preventive Care and Wellness Programs**: Language referring to “hands on” programs remained in this section, although there is clear recognition of the value of coaching, assessments, etc. Thus that language should be removed.

- **Quality reporting activities**: many States and Federal programs require certain quality assurance and quality improvement activities and reports. Quality activities such as those related to completing the HEDIS and CAHPS reports are not just health IT, but include having nurse managers pull files and review patient cases. Such quality review is required as part of the NCQA and URAQ certification health plans undergo. We recommend recognition of those be added in the language under **Other costs**. Here is the proposed revision:

  - **Other costs** for quality improvement initiatives required by states, state programs or federal programs, or as required by, or approved by the Secretary in consultation with the NAIC. This includes quality expenses related to activities performed in developing required reports, such as chart reviews and surveys related to HEDIS and CAHPS reports.

- **HIT expenses**: The language in section Line 5.2 is very specific in limiting the expenses to technology costs. We recommend the re-insertion of the previous language permitting “other costs as approved by the Secretary” in this section, and the related column for other approved HIT expenses reinserted back into the Exhibit – Part 3 (at page 5 of the May 20th exposure draft).

- **HIT expenses exclusions**: We agree, routine upgrades to systems are not quality expenses. However, this language would appear to exclude the transformation of the health care system to the ICD-10 detailed code sets. These updated codes, required by the new federal standards, should be a permitted quality expense, as they explicitly facilitate quality improvements in the three items listed in 5.2. There are numerous places in regulations where HHS states the reason for adoption of ICD-10 is to improve quality and patient safety. (See 74 Fed.Reg. January 16, 2009 at 3330, 3332, 3339 and 3348.) We recommend affirmatively add “including those related to implementation of ICD-10” in the 1st paragraph of 5.2. Here is a proposed revision:
The PPACA also contemplates "Health Information Technology" as a function that may in whole or in part improve quality of care. Include health information technology expenses, including those related to implementation of ICD-10, required to accomplish...

18. A further concern regarding Supplemental Health Care Exhibit – Part 3 is that it appears to expect insurers to break out such costs by state, rather than by programs. Consistent with a state-based supplement, this information could be provided at an aggregate level with an explanation of the method the company used to allocate lines 1.10, 2.10 and 3.10 of Part 3 into the appropriate lines of Part 1 for the various states. This recognizes that companies will often be implementing the programs addressed in Part 3 of the Supplement across their book of business, and thus will need to rely on allocations to provide information at a state level. Including key values used for allocation purposes (earned premium, incurred claims, number of lives) would allow the evaluation of the reported expenses in respect to the business involved while assuring the regulators that they have sufficient information about the allocations to assess their fairness in total.

We thank you for the opportunity to provide comments. We anticipate providing further comments on outstanding issues such as smaller plans, different types of plans and newer plans. If you have any questions or comments please feel free to contact Bill Weller at (623) 780.0260 or at omegasquared@msn.com, Randi Reichel at (301) 774.2268 or rreichel01@comcast.net, Candy Gallaher (202)641-2492 (candy.gallaher@ahip.org).

Thank you.

Sincerely,

Bill Weller
Candy Gallaher

Cc: Randi Reichel
    Todd Sells
May 24, 2010

Lou Felice  
Chair, Health Care Reform Solvency Impact Subgroup  

Steven Ostlund  
Chair, Accident & Health Working Group  

Re: Including Preventive Care, Wellness Services, and Capitated Payments to Non-Physician Providers in the Medical Loss Ratio Numerator  

Dear Mr. Felice and Mr. Ostlund:  

American Specialty Health, Incorporated and its family of companies (ASH) is a leading provider of specialty network management, and prevention and wellness services. ASH provides specialty network management, prevention & health programs including health coaching and fitness programs to health plans, insurers, and employer groups. In its specialty network management programs, ASH provides complementary health care services including chiropractic, acupuncture, naturopathy, dietetic counseling, and occupational, physical and massage therapy. ASH provides evidence-based services in a cost-effective manner.  

We are writing to express our support for two provisions that the Solvency Impact Subgroup has included in its current blanks proposal (released on May 20) for the calculation of the medical loss ratio (MLR). First, we support including preventive care and wellness programs in the MLR numerator as expenses that improve health care quality. Specifically, we support the inclusion in Part 1, Line 5 of the instructions of programs that are related to “wellness assessment, wellness/lifestyle coaching programs, coaching programs designed to educate individual members on clinically effective methods for dealing with a specific chronic disease, and coaching or education programs and health promotion activities designed to change individual member behavior (e.g., smoking, obesity); preventive care and wellness program activities to encourage evidence based medicine; and health information technology expenses to support these activities.” These types of preventive care and wellness services unquestionably have a direct impact on the care provided to health plan members.  

Second, we support including capitation payments to non-physician providers in the MLR numerator as incurred claims. Specifically, we support the provisions in Part 1, Line 2.1 of the instructions that include capitation payments by the reporting entity to non-physician providers for delivery of medical services when those providers are licensed, accredited or
certified to perform specified health services. These types of complementary health services, including such services as chiropractic, acupuncture, naturopathy, dietetic counseling, and occupational, physical and massage therapy, are important components of the care provided to health plan members and are often provided on a capitated basis.

As a result, the current blanks proposal appropriately recognizes the two types of costs described above as dollars expended for “activities that improve health care quality” or “clinical services”, as specified in section 2718.

If we can provide any further information, please do not hesitate to contact me.

Sincerely,

George DeVries
Chairman and CEO
May 18, 2010

David R. White, RHU
President
AmFirst Insurance Company
P.O. Box 16708
Jackson, MS 39236

Dear Mr. White:

Thank you for your letter voicing your concerns on the Health Care Reform bill. I will personally see that it is filed with the proper people at the NAIC.

In the meantime, give my regards to Commissioner Mike Chaney. Your state is very fortunate to be served by Commissioner Chaney. He has been a valued mentor.

Sincerely,

Jay Bradford
Insurance Commissioner

cc: Commissioner Mike Chaney
    Brian Webb, Manager - Health Policy & Legislation
    Todd Sells, Director of Financial Regulatory Services
May 5, 2010

Mr. Jay Bradford, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

Dear Commissioner Bradford:

We are an Oklahoma domiciled insurer who is licensed in your state that sells mostly supplemental medical products. We also market dental and vision plans. Our supplemental medical plans are not major medical plans and solely provide additional coverage for employees whose employer has decided to increase the deductible, co-insurance, or co-pays on the hospital stay or doctors office visit.

We are writing this letter to voice several concerns with the Health Care Reform bill as it relates to our company and other small companies who write not only supplemental medical products, but also major medical plans. We are hopeful that you will pass these concerns to whoever at the NAIC is in charge of writing the rules governing both minimum loss ratios and definitions of what is a health plan related to the Reform bill.

Let me discuss the Minimum Loss Ratio requirement first. If our supplemental medical products are, and I hope and pray they are not, considered "health insurance coverage" under the new law, then the minimum loss ratio requirements will reshape how we market and sell these products or if we can sell them at all. To that end, it is very important to all small companies who write supplemental and major medical products that the premium used to calculate the MLR, minimum loss ratio, be reduced by the amount of reinsurance payments we make to the reinsurers to which we cede premium. Such a deduction of reinsurance costs from premiums subjection to loss ratio requirements would be consistent with PPACA's removal of reinsurance premiums paid to the new public reinsurer of high-risk applicants. That is, PPACA already recognizes the purpose and typical high cost of reinsurance; however, all reinsurance costs should be exempted. Smaller companies especially need reinsurance for two reasons: 1) Reinsurance reduces the amount of risk they take
related to high risk individual insureds. (The new law requires that health plans have no annual maximum and no lifetime maximum amounts.) Small carriers cannot assume the risk alone and from a financial responsibility point of view, and you, as Commissioner, should not want them to assume such catastrophic risks. 2) In many cases, small carriers use reinsurance to reduce the amount of premium we retain in order that our risk based capital ratios continue in the correct range. Without these reinsurance payments, the market will be abandoned to the super large carriers who can assume all of the risk themselves.

My next concerns relate to the definitions and rules that are presently being written. All carriers who write supplemental medical products need a clear statement that these plans are not "health insurance coverage", but rather an "excepted benefit", as consistently defined by IRC 9832 and section 2791 of the Public Service Act, a definition that will exclude them from the coverage requirements (preventative coverage, no annual and maximum lifetime limits, and others) and minimum loss ratio requirements of major medical plans. It was obvious that the writers of the reform bill did not know about or think of supplemental medical products that actually supplement major medical plans. Also, let me clarify supplemental medical products from limited medical or mini medical plans. I am specifically discussing products that are supplemental to major medical plans and not sold to replace major medical plans.

Thank you for listening to our concerns.

Sincerely,
AmFirst Insurance Company

David R. White, RHU, President
May 24, 2010

Mr. Lou Felice
Chair, NAIC Health Reform Solvency Impact (E) Subgroup

By Electronic Mail

Re: Medical Loss Ratios under Public Health Service Act Section 2718

Dear Mr. Felice:

The Blue Cross Blue Shield Association (BCBSA), which is comprised of the 39 independent Blue Cross and Blue Shield Plans (“Plans”) that provide health coverage to nearly 100 million Americans, would like to offer our comments as the National Association of Insurance Commissioners (NAIC) works to provide recommendations to the Department of Health and Human Services (HHS) on Section 2718 of the Public Health Service Act (PHSA), dealing with medical loss ratios (MLRs). We appreciate the opportunity to provide additional comment as the NAIC’s Health Reform Solvency Impact (E) Subgroup continues its work on the Supplemental Health Care Exhibit discussion draft.

1. Health Quality Improvements

We commend the NAIC for seeking to align “Expenses for Health Care Quality Improvements” with activities that Congress considers essential for quality improvement, recognizing that Congress identified a broad range of essential quality improvement activities in Section 2717 of PHSA. The NAIC might also wish to note that in Section 1311, Congress specifies these activities (plus activities to reduce health care disparities) as the essential components of a “quality improvement strategy” for Qualified Health Plans, and Congress also requires that Qualified Health Plans be accredited, a process that itself requires an abundance of quality-improving activities.

Since a health insurance issuer that is a Qualified Health Plan must develop, implement, and report to the Exchange on the broad quality improvement categories specified in Section 1311 – and also carry out all of the accreditation activities listed in Section 1311(c)(1)(D)(i) that increase the likelihood of desired health outcomes – it is
important that the MLR / Quality Improvement definition be consistent with what Congress defined as the essential components of a quality improvement strategy.

To ensure consistency, it is important that the categories included as quality of care expenses, for the purposes of reporting in this supplemental filing and calculating the medical loss ratio, are inclusive of the activities specified by Congress in Sections 2717 and 1311. Therefore, we urge the NAIC to:

- Amend the existing categories to embed the quality improvement activities called for by Congress in sections 2717 and 1311.

- Clarify that quality improvement activities involve both health services for individuals (such as one Plan’s integrated care cancer medical management program that uses skilled care management nurses, decision support tools and community participation to improve the health and quality of individuals with cancer) and health services for populations (such as the programs noted below to eliminate HAIs).

It is especially important that the MLR give full consideration to efforts to reduce healthcare acquired infections (HAIs), which the Agency for Healthcare Research and Quality (AHRQ) identified in its recent 2009 National Health Care Quality Report as one of the most serious patient safety concerns: “In hospitals, safety remains a significant problem… and healthcare associated infection rates are not declining.”

A number of Plans have funded programs to eliminate healthcare-associated infections by implementing HAI monitoring systems and best practices. For example, one Plan partnered with 62 hospitals in a statewide collaborative that saved 209 lives in 2009 by preventing 2,233 HAIs and avoiding 12,819 hospital days.

- Expand the scope of Health IT expenses to ensure that health insurance issuers are able to carry out such quality improving activities as developing and giving members Personal Health Records to help them live healthier lives and manage chronic conditions; helping providers buy or use health IT to improve patient care; or investing in new information systems to measure, analyze, and report quality outcomes to providers and to members.

For example, some Plans have helped subsidize physicians’ adoption of certified Electronic Health Records (EHRs) and helped them obtain and use technology to improve care.

- Add a category for “Quality Reporting” that includes activities at the “front-end,” such as collecting data from providers through manual chart reviews, and at the “back-end,” such as analyzing those data for quality assurance purposes, giving constructive feedback to providers, and giving support to Maintenance of Certification programs that assure physician competency.

For example, one Plan has implemented a program that monitors and measures the
practice patterns of health care providers, assesses those data for variance in practice patterns, and then initiates outreach to providers to ensure that members receive evidence-based care. This program led to practice changes that have resulted in improvements in the quality of care.

We agree, as set forth in Line 5 of the Supplemental Exhibit instructions, that health care quality improvement activities should be designed in ways that can be objectively measured and verified. However, we would caution against requiring measurement and verification on a prospective basis because this would have a chilling effect on innovation, and hinder creative approaches to improving health care quality.

Indeed, the MLR process as a whole should ensure that industry has the needed flexibility to innovate quickly, to design unique programs tailored to their particular markets around health disparities, to discard methods that do not work, and swiftly carry out methods with promise. Therefore, we urge the NAIC not to create hurdles to innovation and swift implementation by adding additional layers of review that need prospective, empirical evidence on performance. Requiring that quality improvement programs must be designed in ways that can be objectively measured and verified will ensure both innovation – the ability to test new approaches or to apply older methods in new settings – and responsibility – since health plans, as fiduciaries for their members’ scarce premium dollars, are unlikely to maintain programs designed to improve quality if measurement and verification show that those programs do not improve quality.

We also would recommend that in creating standards for the MLR, the NAIC give full consideration to maintaining a level playing field among different health plan models. If any particular activity is ultimately excluded as an expense for health care quality improvement, then uniformly it should not be counted as a medical expense, including for group and network model HMOs that may currently report certain quality-improving activities (such as disease and case management and health risk assessments) as medical expenses. This uniform treatment would create a level playing field. Only with such a level playing field would consumers be able to make informed, apples-to-apples comparisons among their health care choices.

Finally, we would note that if the NAIC does not classify quality improvement activities consistent with the intent of Congress as expressed through sections 2717 and 1311 of PPACA, then health plans will face enormous pressures to cut back on these critical activities in order to live within the MLR administrative cap. This is a major concern especially given all the new mandatory requirements that will add to administrative costs (see attached list of near-term examples). Therefore, we hope that the NAIC will add weight to its objective of aligning the MLR with quality improvement activities supported by Congress.

Additional Comments

As noted above, it is important that consumers have meaningful comparisons among all
health plans, including the ability to easily compare medical and administrative spending among different health plans, and in particular, between staff and capitated-model HMOs and other insurance models. To accomplish this objective, all health plans should report costs uniformly. Today, staff and capitated model HMOs report many expenses as “clinical” that other plans include in the “administrative” category (see attached list from the Sherlock Company, a financial consulting firm). A failure to address this discrepancy would mislead consumers because certain HMOs would appear to spend a relatively higher percentage on clinical services costs. Consumers should be able to compare plans on an apples-to-apples basis.

To help ensure the financial reporting under consideration by the NAIC is responsive to PPACA’s MLR requirements and provides meaningful, consistently-reported information for consumers and regulators, we recommend the following:

1. Focus first on those elements specifically required by federal law, and phase in additional reporting not specified by PPACA at a later time. This would promote timely compliance, consistency with market segment rebating requirements, and achieve accurate and meaningful results for consumers and regulators.

To produce the proposed exhibits that go beyond federal requirements, significant systems upgrades are needed to gather and warehouse the data, algorithms need to be programmed (e.g., to allocate items such as investment income, federal income taxes and other expenses), and processes need to be developed to verify the results. The changes must be made within the new internal controls environment prescribed by the NAIC version of Sarbanes-Oxley (as known as the Annual Financial Reporting Model Regulation), which is vitally important but adds time and cost. These systems changes are needed to ensure the accurate, consistent and comparable information that the new federal requirements are intended to produce for regulators and consumers. A phased approach to such systems implementation would best allow us to accomplish those goals while helping to manage administrative costs associated with these systems upgrades.

2. Provide annual rather than quarterly reporting of loss ratio information in order to ensure meaningful information responsive to PPACA requirements. Quarterly reporting may result in misleading data that could cause confusion for regulators and consumers given that it could differ from the annual reporting that will determine the payment of rebates.

Most health insurance products do not have level loss ratios throughout the year due to three main factors including seasonality of claims, seasonality associated with cost sharing (e.g., many plans have calendar year deductibles), and actual claims run-out. Focusing on any single quarter is likely to provide less than full understanding of the health insurers’ results.

3. Line 1.5 - The definition of Federal Taxes and Federal Assessments reads to
exclude federal income taxes on investment income and capital gains. As we understand it, the rationale for the exclusion is based on the assumption that investment income does not relate to the insurance operations of an insurer. However, insurers are statutorily required to hold reserves and capital to sustain the insurance operations. Investment income is generated from the assets supporting these reserves and capital, and not as a separate line of business. We recommend that the exclusion be deleted from the instructions.

4. Line 1.8 is for the reporting of Regulatory Authority Licenses and Fees. The definition specifies the exclusion of fees for examinations by state departments. These examinations, which are in addition to annual external auditor reviews, are required under state insurance laws. They are performed by state regulators, or their subcontractors, with the fees charged directly to the insurer even though the insurer has no control over the amount of the fees. We believe that statutory examination fees meet the definition of regulatory fees, and, therefore, should be included in the definition.

5. We recommend including adjustments for catastrophic (or excess loss) coverage as it is currently a key risk management tool for many small insurers. With the elimination of both annual and lifetime limits as risk management tools in the near future, even larger insurers may need to purchase catastrophic reinsurance to manage the increased risks.

6. Line 3 – Clarify that the arrangements that promote quality Improvements are those set out in federal law.

7. Lines 4.3 - 4.5 are for reporting of incurred rebates to be subtracted from incurred claims. We believe that it is more appropriate to pay any rebates out of premium accounts than claim accounts, as payments to policyholder do not seem to meet the definition of benefits under a policy. Our suggested treatment would also be consistent with the current accounting treatment of experience-rated refund contracts. If rebates are paid as a refund of premium, then the premiums reported in the Statement of Revenue and Expenses would be reduced to reflect the incurred rebates. However, for the MLR rebate calculation, the earned premiums should exclude the issuer’s incurred rebates for the period (i.e., add them back in) as the starting point. In 2014, when the rebate formula uses a three-year average, any prior year rebates need to be shown as incurred claims instead of premium reductions to enable the MLR for those prior years to be shown properly.

*   *   *

Thank you for the opportunity to comment on the NAIC’s Supplemental Health Care Exhibit discussion draft. We look forward to continuing to work with you on this issue.

Sincerely,
Joan Gardner
Executive Director, State Services

cc: Steve Ostlund, Chair, PPACA Actuarial Subgroup
    Todd Sells, NAIC Staff
    Brian Webb, NAIC Staff
    John Engelhardt, NAIC Staff
    Barb Lane, NAIC Staff

Attachments
To:  Alissa Fox  
Senior Vice President  
Office of Policy and Representation  
Blue Cross and Blue Shield Association  

From:  Douglas B. Sherlock, CFA  
President  

Re:  Quality Expenses Delegated in Capitation  

Date:  May 13, 2010  

I understand the Department of Health and Human Services (HHS) and the National Association of Insurance Commissioners (NAIC) are working to develop a definition of “activities that improve health care quality” that would be excluded from the administrative cost category in calculating health plan MLRs.  

It is important to note that many of the activities are already reported by group and network model plans in the clinical category of the MLR. Reporting of these activities varies by plan and also by the contractual relationship between the plan and its providers.  

Examples of activities related to quality that group and network model HMOs may report as medical expenses today are:  

- Care coordination  
- Case management (i.e., more patient-specific intervention than care coordination)  
- Disease management programs  
- Network access fees  
- Network development costs  
- Nurse call lines  
- Costs related to quality measurement/reporting in pay for performance programs  
- Provider credentialing (e.g., ensuring appropriate licensure)  
- Provider education designed to improve quality  
- Certain administrative costs associated with processing claims (including time edits to enforce preventive guidelines, drug abuse quantity limits, bundling rules, etc.)  
- Detection and prevention of payment for fraudulent requests for reimbursement  
- Health IT initiatives  
- Certain investments in claims and other payment systems (e.g., identifying treatment patterns that warrant medical quality review)  
- Patient monitoring programs  
- Health risk assessments
In addition to the items listed above, it is important to note that there are other responsibilities that can be assumed by capitated providers to group and network model HMOs that have the effect of reporting those expenses as health benefits. These include certain customer service activities, the internal payment systems of medical groups (including those similar to claims systems) and information systems costs that support these activities.
Near-Term PPACA Provisions that Add Administrative Costs

There are a number of provisions in the health care reform law that will add to insurers administrative costs in the near-term (before 2014). Following are some examples:

- **Detailed, uniform coverage summaries** for consumers that meet new HHS standards.

- **Notice of mid-year changes** to any modification not included in most recent summary, per above.

- **New “coverage transparency” reporting** to HHS and state insurance commissioner that is made public on claims payment policies/practices, financial disclosures, enrollment/disenrollment data, claims denial and rating practices, cost-sharing and payments for non-network coverage and enrollee rights information.

- **New “cost sharing transparency” reporting** to individuals upon their request of the cost-sharing for specific items or services by a participating provider.

- **New annual quality reporting** to HHS and enrollees of plan activities to improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, and implement wellness and prevention programs.

- **MLR reporting and rebate requirements** following HHS guidelines and methodologies.

- **Immediate insurance reforms** that require major systems and operational changes, including:
  - Out-of-network emergency care
  - Dependent coverage to age 26
  - No pre-existing condition exclusions for children under age 19
  - Consumer choice and access to certain providers (e.g. PCPs)
  - Internal appeals
  - External review requirements
  - No discrimination in coverage or premium based on salary
  - Prohibition of lifetime limits
  - Restrictions on annual limits
  - Coverage for preventive services with no cost-sharing

- **Rate review requirements** with plan justification for “unreasonable” rate increases.

- **Reporting requirements for the new HHS insurance web portal** including insurer-specific information for publication.

- **Maintaining dual systems to account for “grandfathered”** and non-grandfathered plans.

- **New administrative simplification requirements** including adoption of CAQH CORE operating rules and implementation of the unique health plan identifier.
May 25, 2010

Mr. Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup

Steve Ostlund
Chair, Accident & Health Working Group

National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

Dear Messrs Felice and Ostlund:

I am writing on behalf of The Business Council of New York State, a statewide business trade association with over 3,000 members across New York representing all sectors and all sizes of employers. Our members employ over 1 million New Yorkers, and all of our members have a vested interest in ensuring that implementation regulations associated with federal health care reform are carefully crafted to reflect the environment within which New York’s health insurance system functions.

We are writing to comment on the National Association of Insurance Commissioners’ (“NAIC”) development of recommendations related to the calculation of medical loss ratios (“MLR”) in section 2718 of the Public Health Service Act (“PHSA”) as added by the Patient Protection and Affordable Care Act (“PPACA”). The recommendations you are advancing in this regard are critical, as PPACA put a primary emphasis on coverage and very little emphasis on cost containment. It is essential that MLR recommendations not be narrowly constrained limiting New York employers’ flexibility in plan design and their ability continue to offer affordable, quality coverage.

The Business Council urges you to ensure that MLR recommendations recognize the value of health plans in driving quality and ensuring that consumers continue to have access to critical activities that improve the quality and the value of their care. This is very important in New York State – often recognized as a state with among the highest costs in the country – because employers have moved more aggressively into areas which have proven effective in managing employee wellness, allowing employers to better control plan costs without compromising quality. The learning and impact of these employers from implementing chronic disease management programs and employee wellness initiatives has not been limited to large employers. These programs have served to become part of a broader movement toward community wellness initiatives with large employers sharing their experiences and best practices with smaller employers, thus providing a pathway for community-wide efforts to address regional health and wellness issues.
Section 2718 of PHSA allows certain quality measures to be included in the MLR calculation. The Business Council asks that those quality measures which are valuable to employers and their employees be included in the MLR calculation, including: wellness programs, disease management programs, fraud, waste and abuse activities, and certain health information technology tools. These measures provide valuable services to employees improving their health and the value of the care they receive. Failure to include these measures would increase costs for employers, and could jeopardize programs that are valuable to employees and beneficial to their health.

Specifically, we ask that you consider the following:

**Wellness and disease management programs**

Whether offered by an insurer or an employer, we strongly support wellness programs which modify consumer behaviors to improve health and incentivize activities that will lead to a healthier population, whether medical, fitness, or otherwise. Wellness and prevention initiatives have been demonstrated to lead to overall lower costs for consumers by improving their health and well being, and none of them should be considered "administrative."

Wellness programs may include activities such as smoking cessation, health assessments, counseling, fitness programs and the administration of such programs. Similarly, disease management programs provide important care management for employees with chronic and acute conditions. Disease management programs may include activities such as nurse lines, care coordination, special employee communications and other similar activities.

These types of wellness and disease management activities improve health outcomes, increase quality and help to control long-term costs. In drafting PPACA, Congress recognized the importance of wellness and disease management programs as part of an overall health care strategy.

**Health information technology**

Effective health information technology tools help to reduce costs for employers and employees and, by allowing clinical information to be shared among patients and providers, they help to avoid adverse consequences to patients caused by duplicative tests, treatments, and prescribing errors. Personal health records also help employees take control of their own health and become more powerful advocates for themselves. These positive results help to mitigate premium increases and improve the quality of care. As the benefits of health IT become apparent, employers are increasingly demanding more complex health IT solutions in the plans they sponsor for employees.

**Include all quality, fraud and abuse, and cost control initiatives that clearly improve quality and patient safety in the definition of “activities that improve health care quality” including:**

**Quality Programs:** Many activities undertaken already, and many that will be required as a result of PPACA, include the developing, gathering, aggregation, and analysis of data in order to measure and incentivize quality, credentialing of providers, etc. We support such activities, and
believe that both quality and transparency must be paramount in order to make health care more efficient, affordable, and to improve patient care.

**Fraud and Abuse:** Consumers demand that insurers help in efforts to control premium costs, and a key way of doing so is to prevent fraud and abuse. Programs which prevent fraud and abuse improve the quality of care for patients by freeing up funds that would otherwise be wasted, and improve patients’ ability to afford health insurance, as well as their financial freedom.

**Cost Control Efforts:** Consumers are protected from unnecessary costs and get better health outcomes when insurers invest in developing best-practices for providers, aggregating evidence-based guidelines, analyzing the success of health promotion activities in order to refine programs, and analyzing claims data to investigate over- and under-utilization of services. Categorizing broad swaths of cost-control programs as “administrative” is a sure way to drive up premium costs for consumers, thus making it more difficult for them to obtain insurance.

The Business Council of New York State appreciates the task before your group and urges you to consider our thoughts as you finalize your recommendations. Our objective is to ensure that New York employers are not burdened with regulations which so narrowly define an MLR as to cause plan design changes which will drive up costs even further. Our organization stands ready to provide you with any information we can, to help further what we hope is a mutual objective of an affordable health insurance system accessible to New York’s thousands of employers.

Sincerely,

[Signature]

**MM**
May 18, 2010

Mr. Steve Ostlund  
Chair, Accident & Health Working Group  
c/o National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, Missouri 64108-2662

Mr. Lou Felice  
Chair, Health Care Reform Solvency Impact Subgroup  
c/o National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, Missouri 64108-2662

RE: PREMIUM REVIEW PROCESS; REQUEST FOR COMMENTS REGARDING SECTION 2794 OF THE PUBLIC HEALTH SERVICE ACT

Dear Messrs. Ostlund and Felice:

The California Department of Managed Health Care (DMHC or Department) appreciates the opportunity to respond to the National Association of Insurance Commissioners (NAIC) regarding the request for information promulgated by the Department of Health and Human Services (HHS) with respect to premium review processes. For ease of reference, the DMHC’s draft responses to HHS’s questions are attached hereto as Appendix 1. Please note that the attached Appendix 1 represents the DMHC’s preliminary thoughts regarding HHS’s questions; we will provide further and more detailed information and analyses as needed.

We have a number of questions that remain unanswered including federal expectations for state participation in the process of collecting premium information, reviewing premium filings and
enforcement activities as well as how such activities will be reimbursed by the federal government. It is imperative that any state administrative costs for this activity be borne by the federal government and not passed on to California policyholders through higher assessments on insurance premiums.

Background

In California, the health insurance market is regulated by two separate agencies—the DMHC and the California Department of Insurance (CDI). The DMHC oversees health care services for more than 21 million insured Californians, regulating 108 health care service plans (health plans or plans) and certain preferred provider organization products operating in California. CDI regulates all other indemnity health products and touches approximately 2.5 million lives covered by CDI-regulated health insurance products. Another approximately 6.8 million lives are covered by Administrative Service Organization products regulated by CDI.

Of the DMHC’s regulated entities, 54 are full-service plans covering hospital, medical, and surgical services. The remaining plans are “specialized” plans, which cover dental, vision, behavioral or mental health, and chiropractic services. The plans regulated by the DMHC are governed by the California Knox-Keene Health Care Service Plan Act of 19751 (Knox-Keene Act or Act) and the regulations thereunder.

As discussed in detail in Appendix 1, although the Knox-Keene Act empowers the DMHC to enforce many standards to protect consumers, the Act provides the DMHC with limited scope and authority regarding premium rates. In fact, section 1367 of the Act expressly states, “Nothing in this section shall be construed to permit the director to establish rates charged subscribers and enrollees for contractual health care services.”

Despite this broad, general proscription against establishing rates, as discussed in detail in Appendix I, the Act provides certain mandates regarding how premium rates for some types of limited products must be calculated. For example, current California law requires health plans to use certain rating methods when calculating premium rates for small employer (2 to 50 employees) group coverage. Health plans must also comply with specific statutory limits on premium rates for individual conversion coverage products. However, in each of these limited circumstances, the Knox-Keene Act provides the specific rating methods and rate limitations applicable; the DMHC’s authority in those instances is limited to determining whether the rates comply with the methodology or rate limits specified in the Act.

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1 California Health and Safety Code section 1340 et. seq.
Thank you for this opportunity to provide input regarding the NAIC’s response to HHS’s request for information. Should you have any questions, please do not hesitate to contact Sarah Ream or Gary Baldwin, both Senior Counsels in the DMHC’s Office of Legal Services, at (916) 322-6727 or sream@dmhc.ca.gov and gbaldwin@dmhc.ca.gov, respectively.

Sincerely,

Lucinda Ehnes
Lucinda A. Ehnes, Esq.
Director
California Department of Managed Health Care

SR:sr
Enclosure: Appendix 1
Appendix 1—DMHC’s Draft Response to HHS’s Request for Rate Review Information

For ease of reference, HHS’s questions are set forth below in bold, with the DMHC’s respective responses thereto.

A. Information Regarding Regulatory Guidance

1. Rate Filings and Review of Rate Increases

a. To what extent do States currently have processes in place to review premium rates and rate increases?

The Knox-Keene Act generally prohibits the DMHC from establishing the rates charged to subscribers and enrollees for contractual health care services. However, with respect to a few limited types of products, the Act dictates the methodology by which allowable rates must be calculated.

First, the allowable premiums for the Health Insurance Portability and Accountability Act (HIPAA) Guaranteed Issue (GI) products are limited based on the premiums charged to similarly situated enrollees in California’s Major Risk Medical Insurance Program (MRMIP), which is California’s high risk pool. Specifically, for enrollees in a preferred provider organization (PPO), the maximum HIPAA GI premium may not exceed the average premium paid by a MRMIP enrollee who is of the same age and resides in the same geographic region as the HIPAA enrollee. For HMO enrollees, the maximum HIPAA premium cannot exceed 170% of the standard premium charged for a MRMIP enrollee who is of the same age and resides in the same geographic region as the HIPAA enrollee.

Second, a plan may not vary the premium rates for any particular small employer (2-50 employees) group by more than 20% based on specific risk factors of the employees. The risk factors a plan can consider are employees’ age (but limited to age bands), family size, and geographic region within the state.

The DMHC’s review of small group rates is limited to verifying compliance with the above-defined standards. Generally, an actuarial certification of compliance is provided with the small group rate filings. Also, the Knox-Keene Act’s allowable review does not include a comparison of rates from the prior year to assess rate increase for small employer groups.

3 California Health and Safety Code section 1399.811, subdivision (a)(2).
4 California Health and Safety Code section 1357.12, subdivision (a)(1).
5 The allowable age bands are: under 30, 30-39, 40-49, 50-54, 55-59, 60-64, and 65 and over.
6 The allowable family size categories are: single, married couple, one adult and child or children, and married couple and child or children.
7 A plan that operates state-wide may have no more than nine geographic regions in the state. Plans also must not divide a county into more than two regions.
8 In addition to the rate limits discussed above, health plans must also comply with certain statutory limits on premium rates for individual conversion coverage (Health & Safety Code § 1373.621) and Cal-COBRA products.
1. What kinds of methodologies are used by States to determine whether or not to approve or modify a rate or a rate increase? What are the pros and cons of these differing methodologies?

As stated above, the DMHC currently does not have authority to approve most rates or rate increases. However, with respect to small employer group rates, over which the DMHC has authority to confirm that the rates comply with statute, plans file their rates as amendments to their license applications and are not required to obtain DMHC approval prior to use.

Rate filings for HIPAA GI products are also submitted to the DMHC as amendments to the plans’ license applications. If the DMHC finds that a HIPAA GI rate filing does not comply with applicable law, the DMHC will ask the plan to modify its rates to be in compliance.

2. Are special considerations needed for certain kinds of plans (for example, HMOs, high deductible health plans, new policies, and closed blocks of business)? If so, what special considerations are typically employed and under what circumstances?

As discussed above, under current state law the DMHC does not have, except in very limited circumstances, the authority to approve or disapprove rates, and, where the DMHC does have limited authority, that authority extends only to ensuring the plans followed the rate calculation methodology set out in statute.

b. Where applicable, do health insurance issuers currently provide actuarial memorandums and supporting documentation relating to premium rate calculations, such as trend assumptions, for all premium rates and rate increases that are submitted, and/or for all premium rates and rate increases that are reviewed?

The Knox-Keene Act’s implementing regulations require new plan applicants to provide the methods, facts, and assumptions to support their premium rates. Likewise, small employer group rate filings and rate filings for HIPAA GI products generally are accompanied by an actuarial memorandum; however, such memoranda are typically limited to demonstrating compliance with the applicable statutory sections.

1. How is medical trend typically calculated?

The Knox-Keene Act does not include requirements relating to medical trend calculations.

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Cal-COBRA stands for the “California Continuation Benefits Replacement Act”, and provides benefits to small employer groups (less than 20 employees) that are similar to those available under federal COBRA. (Health & Safety Code § 1366.26.)
2. Are specific exhibits, worksheets or other documents typically required? If so, are these documents generally submitted to the State Insurance Department directly, and if so, in what format?

The Knox-Keene Act does not require any specific format for plans to file their HIPAA GI and small employer group rates. However, plans generally file these rates with the DMHC by submitting an explanatory cover letter along with the rate charts broken out by age, family size, and geographic areas.

3. To what extent do issuers use the following categories to develop justifications for rate increases: cost-sharing, enrollee population including health risk status, utilization increases, provider prices, administrative costs, medical loss ratios, reserves, and surplus levels? Are there other factors that are considered?

Plans are not required to file justifications for rate increases unless their HIPAA GI or small employer group rates are found to be out of compliance with the standards discussed in section A.1.a., above.

c. What level(s) of aggregation (for example, by policy form level, by plan type, by line of business, or by company) are generally used for rate filings, rate approvals, and any corrective actions? What are the pros and cons associated with each level of aggregation in these various contexts?

As discussed above, with the exception of HIPAA GI and small employer group rates, health plans are not required to file their rates with the DMHC for approval. HIPAA GI and small employer group rates are broken out by region, product type, enrollee age, and family status (single, married, etc.).

d. What requirements do States currently have relating to medical trend and rating calculations? What are the pros and cons of these different requirements, and what additional requirements could potentially be set?

No comment at this time, as the Knox-Keene Act does not currently have requirements relating to medical trend or rating calculations.
1. Do States generally allow enrollees under the same policy form to be further subdivided for purposes of calculating medical trends and rates?

No comment at this time, as the Knox-Keene Act does not currently have requirements relating to medical trend or rating calculations.

2. Do States generally allow enrollees under different policy forms to be grouped together for these calculations, and if so, how?

No comment at this time, as the Knox-Keene Act does not currently have requirements relating to medical trend or rating calculations.

2. Defining Unreasonable Premium Rate Increases

   a. In States that currently have rate review processes, are all rates or rate increases generally reviewed? If so, for what markets and/or products? If not, what criteria do these States typically use when determining which rates or rate increases will be reviewed? To what extent do States require that these reviews take place before the proposed rate increases can be implemented?

Under current law, the DMHC does not have authority to review rate increases. Rather, as discussed above, the DMHC’s rate review authority is limited to verifying compliance with the statutory requirements for small employer group and HIPAA GI products.

   b. To what extent have States developed definitions of what constitutes a premium rate increase warranting review?

No comment at this time, as the Knox-Keene Act does not currently authorize the DMHC to review rate increases.

3. Public Disclosure

   a. To what extent is information on premium rates and premium rate increases, and related justifications, currently made available to the public?

As required by California law, the DMHC posts on its public website the HIPAA GI rates charged by the various plans offering such coverage.
1. To what extent are annual summaries of premium rate increases currently made available to the public on State or consumer websites, and/or made available by request? Where available, to what extent is this information generally provided by policy form, type of product, line of business, or some other grouping?

No comment at this time, as the Knox-Keene Act does not currently authorize the DMHC to review rate increases.

2. To what extent are rate filings with actuarial justification and supporting documentation generally made available to the public? In what format(s) are rate filings currently made available to the public? What format(s) would be most useful to the public?

No comment at this time, as the Knox-Keene Act does not currently authorize the DMHC to review rates or rate increases, apart from the limited review of HIPAA GI and small employer group products, as discussed above.

3. What kinds of supporting documentation are necessary for consumers to interpret these kinds of information?

The Knox-Keene Act does not currently authorize the DMHC to review rates or rate increases, apart from the limited review of HIPAA GI and small employer group products, as discussed above. However, consideration should be given to whether annual summaries of premium rate increases might be helpful to the public and, if so, what information might be included in such a summary (e.g., types of products offered, lines of business engaged in by a plan).

b. What kinds of information relating to justification for an unreasonable premium increase could potentially be made available?

Please see response to 3.a.3., above.

4. Exclusion from Exchange

a. To what extent have States developed definitions of what constitutes an excessive or unjustified premium rate increase and/or a pattern or practice of such increases? How could a pattern or practice of excessive unjustified premium increases be defined in this context, and what are some of the pros and cons of the various approaches that are available?

No comment at this time, as the Knox-Keene Act does not currently authorize the DMHC to review rates or rate increases, apart from the limited review of HIPAA GI and small employer group products, as discussed above.
b. **What criteria could be established to determine whether insurers have engaged in a pattern or practice of excessive or unjustified premium increases?**

No comment at this time, as the Knox-Keene Act does not currently authorize the DMHC to review rates or rate increases, apart from the limited review of HIPAA GI and small employer group products, as discussed above.

5. **Grant Allocation**

   a. **What factors could be considered in grant allocation?**

   Possible factors for grant allocation might include the number of fully insured (vs. self-insured) individual and group enrollments, participating issuers and products in the state. However, consideration should be given to whether a minimum grant amount should be provided to support the establishment of a rate review system for those states that have fewer enrollees and participating issuers.

   b. **What weighting could be given to different factors and why?**

   More weight may need to be given to the number of participating issuers in the state and other factors that trigger more rate filing reviews.

B. **Information Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act**

   1. **What policies, procedures, or practices of health insurance issuers and States may be affected by Section 2794 of the PHS Act?**

   For regulatory agencies, such as the DMHC, which have limited authority to review rates, Section 2794 may pose significant new review requirements.

   a. **What direct or indirect costs and benefits would result?**

   Benefits might include a greater understanding of the cost drivers in the current system that result in premium rate increases and greater scrutiny of premium increases. Costs might include additional compliance costs for issuers and regulators.

   b. **Which stakeholders will be impacted by such benefits and costs?**

   Impacted stakeholders likely will include health plans, insurance issuers, regulators, enrollees, employers, providers and related industries.
c. Are these impacts likely to vary by insurance market, plan type, or geographic area?

It is unclear as to what the impacts will be; however, individual and small group markets, as well as areas that currently have a high uninsured population, may be impacted.

2. Are there unique costs and benefits for small entities subject to Section 2794 of the PHS Act?

   a. What special consideration, if any, is needed for these health insurance issuers or plans that they sell?

No comment at this time, as it is unclear what special considerations, if any, will be needed.

   b. What costs and benefits have issuers experienced in implementing requirements relating to rate review under State insurance laws or otherwise?

This question is not applicable to the DMHC given the DMHC’s limited rate review authority.

3. Are there additional paperwork burdens related to Section 2794 of the PHS Act, and, if so, what estimated hours and costs are associated with those additional burdens?

Plans will likely incur increased paperwork and costs associated with obtaining regulatory approval of rate changes. Additional costs to the states for performing rate reviews and approvals may also result, including additional cost to hire more actuaries, financial examiners, and legal staff. Accurate estimates of such possible additional costs are not available at this time.

The DMHC currently uses an electronic filing system for most plan filings. However, the hours and costs associated with hiring additional experienced staff to conduct rate reviews could be significant.
May 20, 2010

Steve Ostlund
Chair, Accident & Health Working Group
National Association of Insurance Commissioners

Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup
National Association of Insurance Commissioners

Dear Mr. Ostlund and Mr. Felice:

As you know, the Affordable Care Act included an important consumer protection and cost containment measure to ensure that consumers get value for their premium dollars. Specifically, the law requires insurers to spend a minimum percentage of premium revenue on clinical services and activities that improve health care quality. As members of the Committee on Health, Education, Labor and Pensions, which has jurisdiction over this provision, we write to provide comments on congressional intent. We hope these comments will inform your recommendations to the Secretary of Health and Human Services.

As NAIC has recognized, the statute differs from current practice in recognizing the value of activities that improve quality. While this is important, it also creates a strong incentive for insurers to reclassify as many expenses as possible. Broad categories of activities or “safe harbors,” as some have suggested, would undermine the intent of the law by creating a large loophole.

We therefore urge NAIC to define activities that improve quality with a high degree of specificity, using examples – and in such a way that they can be easily audited by regulators. Such activities should be proven to improve quality based on evidence and standards developed by the Agency for Healthcare Research and Quality, the National Committee for Quality Assurance, or other independent entities. They should also provide direct services to enrollees or directly improve their health or safety.

Some have suggested that “loss adjustment expenses” – administrative expenses incurred in adjusting and settling claims, which include cost containment expenses – should count as spending on clinical services and activities that improve quality. However, while the statute requires reporting of loss adjustment expenses, it is clear that they should not be included for
purposes of determining rebates required under the new law. These expenses do not reimburse for clinical services, and they do not improve quality.

In general, this consumer protection will be most useful to consumers if it recognizes their actual experience to the maximum extent possible. At a minimum, therefore, we urge NAIC to specify a methodology that sets minimum percentages for each market segment in each state. The intent of the statute is clear, because it specifies minimum percentages by market segment and allows states to set higher percentages.

Thank you for the opportunity to provide comments, and for your hard work to accelerate your recommendations to the Secretary. We look forward to working with NAIC as this provision and other health insurance reforms are implemented.

Sincerely,

Tom Harkin
Chairman

Al Franken
Member
May 25, 2010

Mr. Lou Felice  
Chair, Health Reform Solvency Impact Subgroup  
c/o National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, MO 64108-2662  

Re: Medical Loss Ratios – comments on May 20

Dear Mr. Felice:

On behalf of the more than 200 members of DMAA: The Care Continuum Alliance, I respectfully offer the following comments to the May 20th proposed blank for your consideration. Note that our comments are specific to Line 5 – Expenses for Health Care Quality Improvement and the outlined categories.

Based on the number of comments that the Health Reform Solvency Impact Subgroup has received, we thought it would be helpful to provide the rationale for our specific comments below.

Specific recommendations:

1. Care coordination (not just general care management) - the direct interaction between the insurer and the enrollee to coordinate a patient's care between multiple providers (care coordination such as making sure medical records are shared between all the patient's physicians and activities to improve patient safety and reduce medical errors by using best clinical practices, and effective case management such as making/verifying appointments and medication and care compliance initiatives [not involved with chronic disease management]) and arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center and prevention of hospital readmissions); care coordination activities to encourage evidence based medicine; and health information technology expenses to support these activities.

Rationale: The term “direct” is extraneous to the balance of the definition of care coordination and, because it is undefined, a potential source of confusion.

2. Chronic Disease Management Individually tailored chronic disease management programs for specific chronic conditions that interact with the
insured (in person, or via the phone, or other modalities) to provide medication and care compliance initiatives such as: (a) remind insured of doctor appointment, (b) check that insured is following a medically effective prescribed regimen for dealing with the specific disease/condition, (c) incorporating feedback from insured in the management program, (d) provide coaching on dealing with the disease/condition including evidence based information on treatment options; chronic disease management activities to encourage evidence based medicine; and health information technology expenses to support these activities.

Rationale: Including the terms “or other modalities” allows for the evolution of additional innovations (such as remote monitoring devices) for interaction between patients, providers and health plans. The inclusion of the language regarding information on treatment options recognizes the importance of decision aids in patient engagement.

3. Preventive Care and Wellness Programs: Hands on Programs that interact with the insured (in person, or via phone, or other modalities) related to: Wellness assessment, wellness/lifestyle coaching programs, coaching programs designed to educate individual members on clinically effective methods for dealing with a specific chronic disease, and coaching or education programs and health promotion activities designed to change individual member behavior (e.g., smoking, obesity); preventive care and wellness program activities to encourage evidence based medicine; and health information technology expenses to support these activities.

Rationale: Same as rationale for # 2 with respect to allowing for the evolution of technologies and methods for interaction between patients, providers and health plans.

We appreciate your consideration of our suggestions and commend you and your fellow Subgroup members and NAIC staff for the open and transparent way in which you have conducted this process.

Sincerely,

Kip MacArthur
Director Government Affairs

Cc: Steve Ostlund, Chair, Accident & Health Working Group
John Englehardt, NAIC Staff
Todd Sells, NAIC Staff
Brian Webb, NAIC Staff
May 24, 2010

**BY ELECTRONIC MAIL**

Lou Felice  
Chair, Health Care Reform Solvency Impact (E) Subgroup

Re: Request for Information: Medical Loss Ratios; Request for Comments  
Regarding Section 2718 of the Public Health Service Act [75 Federal Register  
119,297 (April 14, 2010)](“RFI”)  

Dear Mr. Felice:

The Federation of American Hospitals (“FAH”) is the national representative of nearly 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, including inpatient rehabilitation, long-term acute care, cancer and psychiatric hospitals. We appreciate the opportunity to provide additional information in response to the NAIC Health Care Reform Solvency Impact (E) Subgroup with respect to the implementation of Section 2718 of the Public Health Service Act (“the Act”).

This letter responds to the Blanks document discussed on the Subgroup’s May 19, 2010 teleconference. On that conference call, the Subgroup indicated that the NAIC’s current plan was to send to the Department of Health & Human Services (“HHS”) by June 1st the proposed reporting form on medical-loss ratio (“MLR”) data, but that it would send definitions and other clarifying information related to the form’s data fields at a later date, planned to be by July 1st. The FAH is greatly concerned about the decision to separate the proposed MLR reporting form from the accompanying definitions, and urges the NAIC to wait until both parts are ready to be able to transmit a complete MLR package to HHS. Because the two parts are integrally intertwined, we believe it would be premature for the NAIC to send HHS one part before the other is complete.

Also, we have particular concerns with Supplemental Health Care Exhibit – Part 3, which provides the underlying data for calculating total costs related to quality improvement activities. We note that the headings for the columns on Part 3 reflect the categories included in the main Supplemental Health Care Exhibit – Part 1. We are concerned about including the “Other Approved Expenses” column in Part 3 when the NAIC does not appear to be proposing at this time any costs that should qualify for that category, as indicated by related Row 5.3 of Part 1 which states “Type C: Other
To include a data field when no costs are identified for inclusion in that category makes the form confusing and subject to misinterpretation and potential abuse. Moreover, in reviewing the remainder of Part 1, the NAIC has not included similar placeholders for other potential cost categories. Therefore, we strongly urge the NAIC to remove Row 5.3 from Part 1 and Column 4 from Part 3 to simplify the reporting form.

On Part 3, we are further concerned about certain rows that have been included for each of the individual, small group, and large group categories. We believe the row titled “Outsourced Services” is vague and overly broad. The draft definition of “Outsource Services” included in Part 3 appears to be completely related to administrative services, stating that what should be included are “expenses for administrative services, claim management services, new programming, membership services, and other similar services,” and only excluding “services provided by affiliates under management agreements.” It is hard to reconcile this definition with the current definition of quality improvement expenses included in Row 5 of Part 1, which properly focuses on costs that can be traced to improved quality of care for individual patients. Therefore, we believe the Subgroup should remove the “Outsourced Services” rows from Part 3.

Regarding accreditation and certification, the FAH has long maintained that, in relation to the provider network management part of the insurers’ business, these services are administrative and record keeping in nature, and do not add to quality improvement of care provided to individual patients. Again, these costs relate to insurers essentially collecting the accreditation and certification status (done by third parties) of the providers in their network. Those expenses should be excluded from the MLR calculation. If this category is meant to include accreditation of the health plan by a third party, then it would be important to closely review the scope of that accreditation program to determine if some of those expenses should be counted for MLR purposes, and those programs do not always relate to the quality improvement for individual patients.

The rows for “EDP Equipment and Software” remain undefined. On its face, it appears that most, if not all, “electronic data processing” equipment and software should relate to administrative services, especially given health information technology costs are specifically addressed in Column 4. In the absence of a clearly understood definition, this category of costs should be deleted from the rows on Part 3.

We understand that there will be another opportunity to consider modifications to the proposed definitions. The FAH looks forward to providing additional input on definitions in the near future. However, one definitional change in the current blanks document deserves mention here.

One material change to the Other Professional Services subcategory (Insured Claims category) is to now include “capitation payments by the reporting entity to such non-physician providers for delivery of medical services to reporting entity prescribers.” In our members’ experience, many capitation programs include metrics related to financial or cost-based performance, and such measures (often categorized as “efficiency measures”) do not qualify as quality improvement activities under section 2718. To the extent a capitation model bases payment solely on objective and measurable quality metrics and pays providers solely for direct care provided to patients, then such activities should be considered incurred claims. Otherwise, the data reporting will exceed those costs which are appropriate under section 2718.
The FAH appreciates the opportunity to provide comments. If you have any questions about our comments or need further information, please contact me or Jeff Micklos of my staff at (202) 624-1500.

Sincerely,

[Signature]

cc: Todd Sells, NAIC
May 14, 2010

Mr. Steven Ostlund, Chair,
Accident & Health Working Group

Mr. Lou Felice, Chair
Health Care Reform Solvency Impact Subgroup

National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO  64108-2662

Dear Mr. Ostlund and Mr. Felice:

I am writing on behalf of Western New York Clinical Information Exchange, Inc. d.b.a. HEALTHeLINK. We are writing to comment on the National Association of Insurance Commissioners’ (“NAIC”) development of recommendations related to the calculation of medical loss ratios (“MLR”) in section 2718 of the Public Health Service Act (“PHSA”) as added by the Patient Protection and Affordable Care Act (“PPACA”). In particular, we have a strong interest in encouraging activities that improve the quality and appropriateness of the health benefits they offer. We, therefore, urge that your guidance on the calculation of medical loss ratios continue to recognize the importance of these value-added services.

HEALTHeLINK is the Regional Health Information Organization for Western New York (WNY) and a recent recipient of a Beacon award from ONC (ARRA stimulus initiative) for the collaborative work we have done in WNY in advancing health information technology. We ask that the MLR calculation include investment in community efforts related to health information technology. Effective health information technology tools help to reduce costs for employers and employees and, by allowing clinical information to be shared among providers on the patients they are treating help to avoid adverse consequences to patients caused by duplicative tests, treatments, and prescribing errors. These positive results help to mitigate premium increases and improve the quality of care.

We appreciate your consideration of our views and encourage you to develop an MLR calculation methodology that will help to ensure that these vital quality improvement efforts are able to continue to meet the needs of patients and the communities we serve.

Sincerely,

[Signature]

Daniel E. Porreca
Executive Director

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Board of Directors:

Michael Cropp, MD - Chair
President & CEO
Independent Health Assoc.

Anthony Billittier, MD
Commissioner of Health
Erie County

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David Scamurra, MD
Pathologist
Catholic Health System

Judy Smith, MD
Executive Medical Director
Roswell Park Cancer Institute

Art Wingerter
President
Univera Healthcare

Executive Director:

Daniel E. Porreca
VIA EMAIL ONLY

May 24, 2010

Mr. Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup
c/o National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Re: May 19, 2010 Draft of Supplemental Health Care Exhibit and Instructions Blanks Agenda Submission Form from Health Reform Solvency Impact (E) Subgroup; Health Care Quality Expenses

Dear Mr. Felice:

On behalf of our client, Healthways, Inc., we are submitting the enclosed comments on the Subgroup’s May 19, 2010 draft of the Supplemental Health Care Exhibit and Instructions. Our comments are reflected in a redlined version of the applicable Instructions in the Blanks Agenda Submission Form, which is enclosed with this letter, and relate exclusively to the current definitions of Health Care Quality Expenses in Lines 5 and 5.1 of the Instructions being developed by your Subgroup.

Healthways is the largest and most experienced health, wellness and chronic care management company in the world. Healthways works with over 1000 employers and more than 100 health plans, and impacts approximately 40 million people a day. Its specialized, comprehensive solutions help people improve their health and well-being, and have been proven to reduce overall health care costs.

We note and appreciate the progress that has been made by you and your Subgroup in developing and refining the definition of health care quality expenses. We believe some further minor amendments to the definition will more adequately capture the intent of the provisions of the Public Health Service Act (the “PHS Act”) which were added by Section 1001 of the Patient Protection and Affordable Care Act, and further clarify the intent of the Subgroup.

In the preamble paragraph of the Line 5 instruction, we would suggest a broader description of the recipients of health care quality services. The current language in the instruction focuses on “patient” health care which may be inferred to suggest that health care quality services are only for those who are sick or injured, while, for example, wellness and prevention programs may well be focused on a health plan’s/insurer’s “members, insureds or enrollees”.

We would also suggest clarifying that the list of services included in categories 1-3 meet the general requirements for health care quality expenses stated in the first, preamble paragraph of
the line 5 instruction. We believe this may be necessary in light of the questions that have arisen during previous Subgroup conference calls as to what is intended by the terminology “that can be objectively measured and verified.”

In the current definition of “care coordination”, interaction is required between the insurer and the enrollee. However, insurers may well contract with other entities to handle certain care coordination. The Subgroup has recognized that certain services are outsourced by including outsourced services as an expense in lines 1.2, 2.2, and 3.2 of the Supplemental Health Care Exhibit – Part 3. We recommend conforming the definition to include recognition that care coordination may be outsourced.

In the definition of chronic disease management, we recommend that the methods of interaction be expanded to include other modalities which would encompass email and web-based communication.

In the definition Preventive care and Wellness programs, we recommend deletion of “hands on” so that interaction in person, via the telephone, or by other modalities would be considered acceptable methods of interaction for providing the described preventive care and wellness services.

While, we believe that it can be inferred from the current definitions that health care quality services are not only those delivered by providers (physicians, nurses, therapists, etc.), we would still recommend that a listing of the types of other acceptable service providers be provided in the definition.

Again, we appreciate all of the effort and thought that you and your Subgroup put into developing the definitions for Health Care Quality Expenses. We do, however, hope that you will consider the comments in this letter and in the enclosed redlined document in crafting your final recommended definitions for the HHS. I look forward to further discussions on these matters in the coming weeks.

Very truly yours,

LOCKE LORD BISSELL & LIDDELL LLP

Norris W. Clark

cc: Todd Sells, NAIC
    Clay Richards, Esq.
    Vicki Shepard
    Shane Doucet
    Denise Hanna, Esq.
Suggested Revisions to Instructions for Lines 5 and 5.1

Line 5 – Expenses for Health Care Quality Improvements

Expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), that are designed to improve health care quality of members, insured or enrollees, reduce medical errors, reduce health disparities, and or advance the delivery of patient-centered medical care in ways that can be objectively measured and verified. Section 2717 of the PPACA Health and health care quality improvement activities described in this Line 5 may be furnished or arranged by a health care provider, a wellness and prevention plan manager or a health, wellness or prevention services organization. Section 2717 of the PHS Act lists the following activities that may in whole or in part improve quality of care as follows:

- effective case management;
- care coordination;
- chronic disease management;
- medication and care compliance initiatives;
- prevention of hospital readmissions;
- activities to improve patient safety and reduce medical errors by using best clinical practices,
- activities to encourage evidence based medicine,
- wellness and health promotion activities.

These activities are embedded in the following 4 categories that will have been determined to fall within the parameters described above and shall be included as quality of care expenses for the purposes of reporting in this supplemental filing and calculating the medical loss ratio (MLR):

1. **Care coordination** (not just general care management) - the direct interaction between the insurer, or an entity who provides these services under contract on behalf of the insurer, and the enrollee to coordinate a patient’s care between multiple providers (care coordination such as making sure medical records are shared between all the patient's physicians and activities to improve patient safety and reduce medical errors by using best clinical practices, and effective case management such as making/verifying appointments and medication and care compliance initiatives [not involved with chronic disease management]) and arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center and prevention of hospital readmissions); care coordination activities to encourage evidence based medicine; and health information technology expenses to support these activities.

2. **Chronic Disease Management** Individually tailored chronic disease management programs for specific chronic conditions that interact with the insured (in person or via the phone or by other modality) to provide medication and care compliance initiatives such as: (a) remind insured of doctor appointment, (b) check that insured is following a medically effective prescribed regimen for dealing with the specific disease/condition, (c)
incorporating feedback from insured in the management program, (d) provide coaching on dealing with the disease/condition; chronic disease management activities to encourage evidence based medicine; and health information technology expenses to support these activities.

3. Preventive Care and Wellness Programs: Hands on programs that interact with the insured (in person or via the phone or by other modality) related to: Wellness assessment, wellness/lifestyle coaching programs, coaching programs designed to educate individual members on clinically effective methods for dealing with a specific chronic disease, and coaching or education programs and health promotion activities designed to change individual member behavior (e.g., smoking, obesity); preventive care and wellness program activities to encourage evidence based medicine; and health information technology expenses to support these activities.

4. Other costs approved by the Secretary, in consultation with the NAIC, which in her discretion, upon an adequate showing that the costs improve the quality of healthcare; the burden shall be on the proponent to show that the costs improve the quality of healthcare.

Note: 24 Hour Nurse Hotlines: Expenses for 24 hour nurse hotlines should be included in care coordination, chronic disease management, and preventive care and wellness programs to the extent they meet those expense requirements. Any other expenses for 24 hour nurse hotlines should be excluded from Improving Health Care Quality Expenses and instead included in Claims Adjustment Expenses.

The following items are broadly excluded as not meeting this criteria:

- 24 Hour Nurse Hotlines except as noted above
- Utilization Review
- Fraud Prevention activities
- Network Management
- Provider Contracting
- Any function not expressly included in Type A items 1 through 4, above

Line 5.1 Expenses for Health Care Quality Improvements other than HIT

Include expenses meeting the Line 5 definition that are not health information technology expenses.
May 25, 2010

Mr. Lou Felice  
Chair, Health Reform Solvency Impact Subgroup  
c/o 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

Dear Mr. Felice:

The Joint Commission is offering comments on the classification of quality improvement and patient safety activities under the definitions to be used to create medical loss ratios consistent with the newly enacted health care reform legislation, The Patient Protection and Affordable Care Act of 2010 (PPACA). Since the beginning of the last century, The Joint Commission has taken a leadership role in promoting advances in quality improvement. Our mission is to continuously improve health care for the public by evaluating health care organizations and inspiring them to excel in their quest to provide safe and effective care of the highest quality and value. Thus we want to ensure that the approach to calculating medical loss ratios does not inadvertently create a chilling effect on legitimate and promising quality improvement activities that can lead to better patient outcomes and enhance the efficiency of care delivery. Our interest in how medical loss ratios are calculated is also driven by our firm belief that high quality care is the most cost-effective care.

The Joint Commission accredits or certifies over 17,000 health care organizations and programs that cover the full continuum of care. For example, our accreditation programs apply to an array of providers and settings in the areas of ambulatory care, acute care, behavioral care, clinical laboratory services, long term care, durable medical equipment suppliers, and home health organizations. As health plans in the envisioned state-based insurance exchanges carry out quality improvement activities in areas of patient safety, preventable hospital readmissions and coordination of care – as envisioned by PPACA in Section 1311 – such plan activities will ultimately involve many of the providers and suppliers that are Joint Commission accredited.

In addition, The Joint Commission is a world leader in raising the bar on quality and patient safety. Our standards, educational programs, publications and consulting are also looked to world-wide for their state of the art guidance and application in a variety of health care delivery situations. As one indicator of the global recognition of our
leadership in advancing patient safety solutions, we are the only World Health Organization designated collaborating center on patient safety.

A number of years ago, The Joint Commission developed a robust program of performance measurement that included the first national, standardized set of evidence-based quality of care measures for hospitals—measures that are now the basis of today’s Medicare reporting program for hospitals, codified in law, and referenced in PPACA. Many of the measures in our hospital program will, because of language in both the American Responsibility and Recovery Act and the Patient Protection and Affordable Care Act, become integrated into the definitions of “meaningful use” of electronic health records required to be met in order that Medicare certified hospitals receive incentive payments for adoption of electronic health record systems. But the overwhelming contribution of The Joint Commission’s program on measurement has been the documented and extraordinary effect it has had on dramatically increasing the adherence by our nation’s hospitals to critical processes of care that are closely related to improved patient outcomes. Few other programs to improve provider performance have had such a profound and national effect.

Recently, The Joint Commission launched a new initiative, the Center for Transforming Healthcare, which will help shape the future of health care delivery by developing and deploying durable and generalizable solutions to pressing quality and safety problems. Together with a key group of the nation’s leading hospitals and health systems, the Center identifies and tests quality improvement interventions and solutions by using the same robust process improvement tools that other industries have long relied on to improve quality, safety and efficiency. The Joint Commission then spreads these proven interventions to all its accredited organizations.

We applaud the NAIC’s effort to develop clear and concise definitions in the “exposure draft blank and instructions” that have been recently proposed. The Joint Commission understands very well the challenge that the NAIC faces in trying to appropriately define quality improvement activities for the purpose of calculating medical loss ratios. It is imperative that expenses allowed for quality improvement efforts are expenses designed to have a positive effect on patient and population health. Activities with little opportunity to make a difference in health outcomes should be excluded as legitimate costs in order to protect insurance premiums from unreasonable cost increases.

At the same time, it is important that there be sufficient latitude in the definition of allowable quality improvement expenses to encourage and support innovative approaches to quality improvement. While we want to strive toward as much evidenced-based quality improvement as possible, we do not have a large portfolio of activities that meet that test, and evaluations to demonstrate cost-effective implementation of many quality
improvement strategies is expensive. Unfortunately, this country has not made substantial investments in systematically identifying scientifically-based quality improvement efforts that have also been tested and evaluated for their effectiveness, which is precisely why The Joint Commission launched the aforementioned Center for Transforming Healthcare and lobbied heavily for inclusion of Section 3501 in PPACA to fund similar types of empirically-based quality improvement work. The Joint Commission’s quality improvement and patient safety work in its new Center is illustrative of the significant resources it takes to develop cost-effective, well tested and durable quality solutions.

Consequently, many quality improvement strategies are reasonable for insurers to engage in because of their likelihood to result in better care and services, but cannot yet meet a rigorous requirement that they are evidenced-based. Until such time as there is more empirical evidence, insurers should not be discouraged from engaging in activities with a generally accepted, strong and close causal relationship between the quality improvement expenditures and the anticipated population or enrollee outcome. The Joint Commission does support, however, the draft NAIC language that would require that quality improvement activities be designed in a manner that can be objectively measured and verified. In this way, insurers will be able to prospectively evaluate which of their strategies are effective should results appear to be of questionable value. We would suggest strengthening this language to add the concept that the strategies should be well designed in their methodology, approach and plan for execution to achieve their specific intended purpose.

Quality improvement activities that The Joint Commission recommends for inclusion in “Expenses for Health Care Quality and Improvements” are:

- Performance measurement and reporting activities that include data analysis, timely feedback of results, and the use of performance information in quality improvement strategies. It is important to note here that for many measures, medical chart abstraction or record review is still a necessity and should be considered an allowable cost for quality improvement.
- Costs for accreditation/certification expenses, including the costs associated with compliance with accreditation requirements. Accreditation is associated with risk reduction and has been shown to correlate with better adherence with the clinical processes that underlie many performance measures.
- Quality improvement activities referenced in Sections 2717 and 1311 of PPACA.

Lastly, we would like to caution that the proposed category of “Other costs approved by the Secretary, in consultation with the NAIC, which in her discretion upon an adequate
showing that the costs improve the quality of health care…” could be used to create a very high bar for deciding legitimate costs for conducting quality improvement strategies.

The Joint Commission appreciates the NAIC’s efforts and willingness to reach out for public input to inform the medical loss ratio dialogue. We urge you to develop unambiguous definitions wherever possible, but to also consider both including the specific items listed above and a safe harbor for well designed quality improvement activities where there is a broad consensus that they are strongly associated with better individual and population outcomes. These strategies will ultimately provide the most value for the public and thereby have a positive effect on overall health care costs.

Please do not hesitate to contact me or Margaret VanAmringe, Vice–President for Public Policy and Government Relations in our Washington Office. She can be reached by telephone at 202.783.6655 or by email at mvanamringe@jointcommission.org

Sincerely,

Mark R. Chassin, MD, MPP, MPH
President

Cc: Richard Diamond, Chair, Actuarial MLR Subgroup
    Todd Sells, NAIC staff
    John Englehart, NAIC staff
    Brian Webb, NAIC staff
Dear Mr. Ostlund and Mr. Felice:

I am writing on behalf of Lifetime Health Medical Group, a primary care provider serving nearly 100,000 patients in the Upstate New York area. Lifetime Health offers primary care, urgent care and specialty services throughout 12 locations, providing quality, innovative and patient-centered care to the diverse patient populations in the region. We are writing to comment on the National Association of Insurance Commissioners’ ("NAIC") development of recommendations related to the calculation of medical loss ratios ("MLR") in section 2718 of the Public Health Service Act ("PHSA") as added by the Patient Protection and Affordable Care Act ("PPACA"). In particular, we have a strong interest in encouraging activities that improve the quality and appropriateness of the health benefits they offer and the health status of their employees. We therefore urge that your guidance on the calculation of medical loss ratios continue to recognize the importance of these value-added services.

We ask that certain valuable quality measures be included in the MLR calculation, including: wellness programs, disease management programs, fraud, waste and abuse activities, and certain health information technology tools. These quality measures provide valuable services to employees by improving their health and the value of the care they receive. Failure to include these measures would increase costs for patients and their employers, and could jeopardize programs that are valuable to patients and beneficial to their health.

We are currently engaged with HealthNow in our Buffalo area practices in a novel patient-centered medical home initiative where we are being supported in various ways financially, including support toward NCQA certification, pay-for-performance quality incentives, and engagement in advancing local health information exchange development through enhanced health information technology. We have similar
arrangements with Independent Health Associates in Buffalo, as well as Excellus Health Plans and MVP in Rochester, NY around incentives for quality of care improvement activities. Fidelis Health Plan is also working with us and other providers around promoting wellness and disease management. All of the payors listed above are focusing on similar quality measures via pay-for-performance type incentives, including increased wellness visits, high quality diabetes and asthma management, and high levels of preventive services (mammography screening, colorectal cancer screening, sexually transmitted disease screening, etc.). Most of the above payors are also adding incentives to increase generic prescribing, which lowers out-of-pocket costs for patients and inherently will improve medication compliance and patient safety.

We appreciate your consideration of our views and encourage you to develop an MLR calculation methodology that will help to ensure that these vital quality improvement efforts are able to continue to meet the needs of our patients and the communities we serve.

Sincerely,

Douglas Golding, MD
Medical Director & CMIO
Lifetime Health Medical Group
120 Gardenville Parkway
West Seneca, NY 14224
May 24, 2010

Mr. Lou Felice, Chair
Health Reform Solvency Impact (E) Subgroup
c/o National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

RE: NAIC Life and Accident & Health Blank (May 20th Discussion Draft)
SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1, Line 3 & Line 5.

VIA ELECTRONIC MAIL

Dear Mr. Felice:

As Consumer Representatives representing millions of patients, consumers and workers, we appreciate the diligent and disciplined process that the NAIC has used to ensure meaningful participation of all stakeholders in developing definitions and instructions for recording the various expenses related to implementing the immediate market reforms pursuant to the Patient Protection and Affordable Care Act of 2009 (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA).

As requested, we are writing to provide you with our comments and proposed modifications to the definitions in the May 20th Discussion Draft of the NAIC BLANKS (E) WORKING GROUP SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1 Line 3--Incurred Medical Incentive Pools and Bonuses and Line 5--Improving Health Care Quality Expenses Incurred. The expenses reported in Line 3 and Line 5 relate to Section 2718 in the new law that requires health plans to report on the proportion of premium dollars spent on clinical services and activities to improve health care quality and other costs, and provide rebates to consumers if the amount of the premium spent on clinical services is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets.

Our comments focus on general principles that should be incorporated into the definition of activities to improve health care to meet the legislative intent of the law. In general when implementing the MLR requirements, the NAIC Blank Instructions should:

- Provide clear and consistent definitions and a methodology to be used by insurers that will allow unambiguous and transparent allocation of expenses to the categories recognized by the rule. In particular, “activities that improve health quality” must be clearly defined so as to exclude general administrative expenses including fraud prevention and cost containment activities.
- Not create unintended disincentives for insurers to reduce their investment in evidence-based preventive services, disease management, case management, and
quality improvement programs that may currently be considered administrative or medical costs, depending on the legal structure of the health plan and the product.

- Include evidenced based clinical performance, outcomes and patient experience measures that are evaluated annually and reported in the annual Quality Improvement Program Report to the Secretary and applicable state regulatory entity or exchange.
- Distinguish between quality improvement activities consistent with PPACA’s quality agenda and reporting requirements (e.g., chronic disease case management quality reporting, patient-centered health promotion and counseling, care compliance, etc.) and those associated with quality assurance (QA) that are basic health plan administrative functions (e.g., network development and provider credentialing expenses, utilization review, etc.)

The proposed modifications to the May 20, 2010 Discussion Draft SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1 Instructions are shown below:

Line 3 – Incurred Medical Incentive Pools and Bonuses

**Line 3.1 – Shared Savings Arrangements**

Arrangements with contracted providers and other risk sharing arrangements whereby the reporting entity agrees to share savings.

**Line 3.2 – Provider Reimbursement Structures**

Arrangements with contracted providers to improve health outcomes through provider reimbursement structures including but not limited to pay for performance, bundled payments, medical homes models and other activities that involve reimbursement of contracted providers including physicians, hospitals, pharmacists or other licensed health care professionals as part of implementing activities to improve health care quality.

Line 5 – Expenses for Health Care Quality Improvements

Expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), that are designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care in ways that can be objectively measured and verified. These activities should be grounded in evidence-based medicine, widely accepted best clinical practice, or standards issued by medical professional associations, accreditation bodies or government agencies. Section 2717 of the PPACA lists the following activities that may in whole or in part improve quality of care as follows:

- effective case management;
- care coordination;
- chronic disease management;
- medication and care compliance initiatives;
- prevention of hospital readmissions;
- activities to improve patient safety and reduce medical errors by using best clinical practices;
- activities to encourage evidence based medicine;
- wellness and health promotion activities.

These activities are embedded in the following 5 -categories that may be included as quality of care expenses for the purposes of reporting in this supplemental filing and calculating the
medical loss ratio (MLR) if the expenses are demonstrated to be achieving the intended quality purposes (either through external oversight or internal evidence available in an auditable format):

1. **Care coordination** (not just general care management) - the direct interaction between the insurer and the enrollee to coordinate a patient's care between multiple providers (care coordination such as making sure medical records are shared between all the patient's physicians and activities to improve patient safety and reduce medical errors by using best clinical practices, and effective case management such as making/verifying appointments and medication and care compliance initiatives [not involved with chronic disease management]) and arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center and prevention of hospital readmissions); care coordination activities to encourage evidence based medicine; and health information technology expenses to support these activities.

2. **Chronic Disease Management** Individually tailored chronic disease management programs for specific chronic conditions that interact with the insured (in person or via the phone) to provide medication and care compliance initiatives such as: (a) remind insured of doctor appointment, (b) check that insured is following a medically effective prescribed regimen for dealing with the specific disease/condition, (c) incorporating feedback from insured in the management program, (d) provide coaching on dealing with the disease/condition; chronic disease management activities to encourage evidence based medicine; and health information technology expenses to support these activities.

3. **Preventive Care and Wellness Programs**: Hands on programs that interact with the insured (in person or via phone) related to: Wellness assessment, wellness/lifestyle coaching programs, coaching programs designed to educate individual members on clinically effective methods for dealing with a specific chronic disease, and coaching or education programs and health promotion activities designed to change individual member behavior (e.g., smoking, obesity); preventive care and wellness program activities to encourage evidence based medicine; and health information technology expenses to support these activities.

4. **Quality improvement and quality improvement reporting**: Expenses related to measuring, reporting quality, aggregating and using data to assess and improve clinical performance, health outcomes and patient experience to comply with federal and state regulatory, accreditation or Health Plan QI Program requirements that are not included in Line 5.2. This allowance is intended to promote and ensure that quality, outcomes and patient experience data are consistently measured and in a manner that is available for appropriate oversight bodies and the consumer. Examples may include maintaining and reporting the certified health plan’s local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set (HEDIS), or patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey by any entity recognized by the Secretary for the accreditation of health insurance issuers.

5. **Other costs** approved by the Secretary, in consultation with the NAIC, which in her discretion, upon an adequate showing that the costs improve the quality of healthcare; the burden shall be on the proponent to show that the costs improve the quality of healthcare.

Note: 24 Hour Nurse Hotlines: Expenses for 24 hour nurse hotlines should be INCLUDED IN CARE COORDINATION, CHRONIC DISEASE MANAGEMENT, AND PREVENTIVE CARE AND wellness programs to the extent they meet those expense requirements. Any other expenses for 24 hour nurse hotlines should be excluded from Improving Health Care Quality Expenses and instead included in Claims Adjustment Expenses.

The following items are broadly excluded as not meeting this criterion:
- 24 Hour Nurse Hotlines, except as noted above
- Utilization Review
• Fraud Prevention activities
• Network Management
• Provider Contracting
• Quality Assurance Activities
• Costs associated with calculating and administering individual enrollee or employee incentives. This includes rewards or bonuses associated with wellness or health promotion programs (e.g., reductions in individual enrollee or group health plan copays, deductibles or premiums based on achieving specified health outcomes or engaging in specified health promotion activities).
• Any function not expressly included in Type A items 1 through 4, above

Line 5.1 – Expenses for Health Care Quality Improvements other than HIT

Include expenses meeting the Line 5 definition that are not health information technology expenses.

Line 5-2 – HIT Expenses for Health Care Quality Improvements

The PPACA also contemplates “Health Information Technology” as a function that may in whole or in part improve quality of care. Include health information technology expenses required to accomplish the activities reported in Line 5.1, that are designed for use by health plans, health care providers, or patients for the electronic creation, maintenance, access, or exchange of health information in the following ways;

• Monitoring, measuring, or reporting clinical effectiveness;
• Advancing the ability of providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently;
• Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

Exclude:
Costs directly related to upgrades in HIT that are required to be made in order to comply with new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended. (Discuss – Exclude as administrative or include as Fed requirement)

Line 7.1 – Cost Containment Expenses not Included in Quality of Care Expenses in Line 5.4

Include: Expenses that actually serve to reduce the number of health services provided or the cost of such services. Exclude cost containment expenses which improve the quality of health care reported in line 5.4. The following are examples of items that shall be considered “cost containment expenses” only if they result in reduced levels of costs or services:

Post and concurrent claim case management activities associated with past or ongoing specific care;
Utilization review;
Detection and prevention of payment for fraudulent requests for reimbursement;
Expenses for internal and external appeals processes.
Network access fees to Preferred Provider Organizations and other network-based health plans (including prescription drug networks), and allocated internal salaries and related costs associated with network development and/or provider contracting.

We appreciate this opportunity to submit comments. We thank you for your effective leadership in facilitating the Health Reform Solvency Impact (E) Subgroup to ensure that the work is completed in accordance with the required timeframes. If you have any questions, please contact Wendell Potter at wenpotter@gmail.com or Mark Schoeberl at mark.schoeberl@heart.org.

Sincerely,

Mark Schoeberl
Wendell Potter
Timothy Jost
Barbara Yondorf
Georgia Maheras
May 24, 2010

Mr. Lou Felice  
Chair, Health Reform Solvency Impact Subgroup  
c/o 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 Mr. Felice:

We are writing to respond specifically to the new exposure draft blank and instructions you circulated. We strongly support the new language you have added to the exposure draft that would align NAIC’s medical loss ratio instructions with some of the federal definitions of activities that improve quality. However we remain concerned that some important activities – namely a full accreditation program and some types of data collection and reporting on quality -- may not count as activities that improve quality. This would discourage plans from this important investment.

The Institute of Medicine, in its important report on Crossing the Quality Chasm, defined quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." The six aims for quality improvement are that health care has the following attributes:

- Safe
- Effective
- Patient centered
- Timely
- Efficient
- Equitable

NAIC’s consumer representatives have strongly supported quality improvement activities that include a performance measurement strategy. All of NCQA’s programs rely on measurement – all programs measure structures in place, and we put a premium on developing, collecting, and reporting measures of clinical and patient experience. For new programs, we have learned that a mixture of structure and process measures is usually the place to start, and we add clinical and patient experience measures over time. In our health plan accreditation program, for example, the weight given to clinical and patient experience measures in calculating a plan’s score has grown to 44 percent. But we have found that the other structure and process measures continue to be important to make sure that policyholders have access to care – a sufficient number of high quality providers, information about their benefits and plan rules and making sure that utilization review programs rely on evidence rather than being arbitrary in nature.

A very recent study published in the International Journal for Quality in Health Care by Laurence Baker and David Hopkins has found that health plans are able to affect quality above and beyond what the providers in the network are able to achieve. This study underscores the importance of holding health plans accountable for engaging in quality improvement work. It also emphasizes the value of private

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state and federal activities to provide requirements and incentives to challenge health plans to make the investments in and commitments to improving the quality of care.

Measuring and reporting quality of care is a critical activity that supports the improvement of patient care and is an essential requirement for evaluation of many delivery system reform initiatives at the state and federal level. You have added new language to the definition of HIT Expenses for Health Care Quality Improvement to include:

- Monitoring and measuring or reporting clinical effectiveness
- Advancing the ability of providers, insurers or other systems to communicated patient-centered clinical or medical information rapidly, accurately and efficiently; and
- Tracking whether a specific class of medical interventions or a bundle of related services leads to better outcomes.

These would seem to include the measures that we and others would want to hold plans accountable for high quality care. However, we recommend that you modify the title of the category to read “Data Collection and HIT Expenses for Health Care Quality Improvement” to make sure that measures collected through chart review and telephone and mail surveys are included.

We are pleased to see that you are allowing health plans to allocate accreditation and certification expenses to some of the activities that improve quality. We recommend that the draft blank clarify that all of the cost of accreditation (the direct cost and the cost of actually complying with our standards) be allowed to count in this category. Accreditation is making sure that all these functions meet challenging standards that assure that patients have access to care. It may be interpreted from the draft blank that some portion of accreditation fees would be counted as administrative costs. This would have the unintended consequence of discouraging plans from undergoing the entire accreditation program and instead only accredit some aspects of their program.

NCQA would be pleased to meet with the NAIC and the Administration to let you know about the programs – including performance measures -- we have developed to evaluate care management and the other activities listed on the forms. We also would be happy to work with you to develop a strategy for reviewing quality activities that plans might propose going forward – for example, developing consistent evaluation frameworks.

Thank you for your consideration of these comments.

Please do not hesitate to contact me or Sarah Thomas, Vice President of Public Policy and Communications at (202) 955-1705.

Sincerely,

Margaret O’Kane
President

Attachment

cc: Richard Diamond, Chair, Actuarial MLR Subgroup
Todd Sells, NAIC Staff
John Englehart, NAIC Staff
Brian Webb, NAIC Staff
Attachment: NCQA Accreditation Process Overview

Achieving Improvement Through Measurement

NCQA Health Plan Accreditation includes two major components on which a plan’s performance is scored: standards, an evaluation of the plan’s structure and processes to maintain and improve quality in five core areas; and Healthcare Effectiveness Data and Information Set (HEDIS®1), an evaluation of the plan’s performance on process and outcomes in clinical care and patient experience of care.

NCQA standards evaluate the following categories:

Quality Management and Improvement
- A health plan’s systems for continuous improvement of quality of care and service.
- How the plan makes sure that members have access to the care they need.
- Specific plan programs that help members with chronic illnesses (e.g., disease management and complex illness or trauma; case management).

Utilization Management
- How fair, consistent and prompt is the plan when it makes decisions about medical necessity for medical, behavioral health and pharmacy services?
- Does the plan use evidence-based clinical guidelines and clinical staff—including physicians—to make decisions?
- Does the plan have a process for members to appeal its medical necessity and coverage decisions?

Credentialing
- How thoroughly the plan investigates qualifications and practice history before allowing a physician to join its network.
- The plan’s process for ongoing evaluation of the physicians in its network.

Members’ Rights and Responsibilities
- Does the plan clearly inform its members about how to get care and use its services?
- Does the plan have a process to respond to member concerns and complaints?
- How the plan protects members’ personal information.

Member Connections
- How the plan distributes important information to members, such as their health status, plan resources, member care options and the cost of different services and prescription drugs.
- How the plan promotes wellness and prevention to its members.

HEDIS measures evaluate areas of care
- Preventive services, such as child and adult immunizations, cancer screenings, prenatal care and smoking cessation.
- Treatment of acute illnesses, such as respiratory infection and pharyngitis in children and bronchitis in adults.
- Management of chronic illnesses, such as diabetes, high cholesterol, high blood pressure, asthma and depression.
- Patient experience2 with the services provided by the plan and by the physicians in the plan’s network: how quickly members can access care, how members rate their personal physician, the claims process, customer service and overall rating of the plan.
NCQA’s rigorous survey process consists of onsite and offsite evaluations conducted by a team of physicians and managed care experts. The offsite survey reviews the plan’s self-evaluation and other materials submitted to NCQA through the Interactive Survey System (ISS), the first Web-based tool for health plan accreditation. The ISS provides guidance and feedback to the plan while it performs a survey-readiness evaluation against NCQA Accreditation standards. The survey team reviews the plan’s submitted documentation for compliance with the standards.

The onsite survey is a two-day visit, during which NCQA surveyors interview plan staff and review materials that cannot be submitted via the ISS, such as actual case records, meeting minutes and other confidential documents.

1 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
2 Based on CAHPS® (Consumer Assessment of Healthcare Providers and Systems), a standardized survey used by all plans.
3 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
May 20, 2010

Mr. Lou Felice  
Chair, Health Reform Solvency Impact (E) Subgroup  
C/- New York Department of Insurance  
25 Beaver Street  
New York, New York 10004-2319

Re: Medical Loss Ratios; Request for Comments Regarding Section 2718 of the Public Health Service Act

Dear Mr. Felice:

On behalf of the New Jersey Chamber of Commerce, I appreciate the opportunity to provide the U.S. Department of Health and Human Services (HHS) with comments and recommendations in response to Section 2718 of the Public Health Services Act governing premium transparency and medical loss ratios, as mandated in the Patient Protection and Affordable Care Act (PPACA).

As a leading organization representing businesses across New Jersey we have a longstanding commitment to the health of our citizens and of our economy.

We support many elements of the recently passed Health Care Reform legislation, particularly as it expands access to health insurance. However, we are concerned that new regulations concerning minimum medical loss ratios may have the consequence of reducing the level of resources devoted to health screenings, disease prevention, patient education, and direct support for those suffering from heart disease and other acute and chronic conditions.

Specifically, we believe that health plan resources devoted to improving patients’ health are properly categorized as medical rather than administrative costs. Such programs would include: wellness and prevention programs (including managing high blood pressure and cholesterol), case management and disease management, care coordination, quality reporting, incentives to promote evidence based medicine, programs designed to ensure patient safety, and programs that reduce avoidable hospital admissions and readmissions.
If the final regulations fail to properly categorize these activities, they and the value they provide to clinicians and consumers, will be seriously undermined. This would have a negative consequence on individuals and their families, as well as the economic health of our state.

Thank you for this opportunity to comment on the proposed regulations and we hope the outcomes will be supportive of our shared goal of a healthier America.

Sincerely,

JOAN VERPLANCK
President

JV: 2734

cc: Tom Considine, Commissioner
    NJ Department of Banking and Insurance

    Todd Sells
    Director Financial Regulatory Services, NAIC
May 26, 2010

Re: Medical Loss Ratios Under Section 2718 of the Public Health Services Act

Dear Colleagues:

New Jersey has a long history of administering medical loss ratios and overseeing the payment of associated rebates. We have seen firsthand the power that they can have in ensuring premiums are reasonable in relation to claims and in incenting the design of appropriate cost-structures. We also know that a too-rigid structure can result in discouraging programs that would benefit the participants of the program.

Insurance companies cannot be given license to re-brand administrative overhead as ‘quality initiatives’ to evade the minimum loss ratio requirements. Some commenters have suggested that the legislation requires including all loss adjustment expenses including claim payment expenses in the numerator of the calculation, i.e. the “medical” side of the fence. We urge outright rejection of such a position.

On the other hand, the rules cannot define quality initiatives so narrowly that value-added programs that do increase quality and hold down unnecessary costs are discouraged. This is a particular risk in the large group market where the loss ratio requirement is more aggressive at 85%. The statute did clearly make provision for including the cost of quality initiatives with claim costs in the numerator of the ratio as “medical costs.” Many of the comments received by the NAIC appear to be aimed at eviscerating the language of the law rather than giving it meaning, as this body has been charged to do.

Viewed in a vacuum, loss ratio requirements create perverse incentives because as premiums increase, permissible expenses and profits increase. Conversely activities that bring down medical costs and therefore premiums add expenses while shrinking the allowable collectible premium. Market demands for cost containment and competition will encourage initiatives to improve quality while holding down unnecessary costs, unless thwarted by regulatory requirements.
To illustrate, assume a carrier is operating at an 84% loss ratio in the large group market, with premiums of $500 per member per month. Claims expenses are therefore $420 PMPM, with $80 available for expenses and profit. A cost containment initiative becomes available that would improve quality while reducing hospital stays and readmissions by $4 PMPM, at a cost of $2 PMPM. If this initiative is required to be accounted for as administrative expense, claims expenses are now $416 PMP ($420–$4), leaving $489 as the maximum permissible premium ($416/85%). The initiative would cause the carrier’s permitted expense and profit amount to go down by $7 while its expenses would rise by $2. The carrier therefore must spend $2 more, of a reduced premium dollar, and would keep $7 less. If required to be accounted for as expense rather than quality improvement, such a program would likely not be pursued. Utilization review programs do improve quality by limiting the number of potentially risky health interventions to which an insured is otherwise exposed.

While the example is simplified, the dynamic illustrated is very real.

An area of opportunity in which regulators, insurers and health care providers have shared responsibilities to advance is electronic health records. We usually think of premium dollars as composed of two independent buckets – medical costs and administrative costs. Electronic health records represent a unique opportunity to drive down both cost components, while at the same time increasing quality of care. We have to move to a future where duplicate tests are avoided because clinicians have access to a patient’s entire health record, where allergic reactions are avoided because emergency rooms have access to the patient’s health history, and where the cost and hassle of claim payment is reduced because insurers can get the medical records they require for review without faxing back and forth to the hospital. Investments in Health Information Technology initiatives aimed at improving care and reducing errors should be considered quality initiatives.

Attached is a copy of a May 19 letter sent to Lou Felice on behalf of the New Jersey Chamber of Commerce. I fully support and endorse their recommendations. I would urge the NAIC’s proposed definition of quality improvement initiatives incorporate the following concepts:

Quality improvement includes programs to educate members, reduce unnecessary care, improve health outcomes, and incent the delivery of cost-effective care, including:

- Hotlines providing members with access to clinical personnel including RNs;
- Wellness and Disease Management Programs;
- Utilization Review Programs;
- Technology Health Information errors, such initiatives aimed at improving care and reducing as Electronic health records and implementation of ICD-10;
- Provider bonuses;
- Member education, including clinical and cost transparency information;
- On-site clinics and health kiosks; and
- Health risk assessments.
The term should not be defined as a closed list that would preclude the development of future programs.

I look forward to continuing to work on these issues with you.

Very truly yours,

[Signature]

Thomas B. Considine
Commissioner

Attachment
May 21, 2010

The Honorable Lou Felice  
Chair, Health Reform Solvency Impact (E) Subgroup  
C/O New York Department of Insurance  
25 Beaver Street  
New York, NY 10004-2319

Re: Medical Loss Ratios - Request for Comments  
Section 2718 of the Public Health Service Act

Dear Chairman Felice:

On behalf of the New Jersey Business & Industry Association, I appreciate the opportunity to provide the National Association of Insurance Commissioners with comments regarding medical loss ratios, as mandated in the Patient Protection and Affordable Care Act.

The New Jersey Business & Industry Association is an employer association providing information, services and advocacy for its member companies in order to build a more prosperous New Jersey. We are the nation's largest statewide employer association. We have 22,000 member companies in all industries and in every region of New Jersey. As a group, our members employ more than one million people, about one-third of the State's private-sector workforce.

We support many elements of the recently passed Health Care Reform legislation; particularly those aimed at keeping health insurance affordable for small business—long our members’ biggest concern. However, we are concerned that new regulations concerning minimum medical loss ratios may have the consequence of reducing the level of resources devoted to health screenings, disease management programs, patient education, wellness programs, fraud, waste and abuse activities, and certain health information technology tools.

These quality measures provide valuable services to covered employees improving their health and the value of the care they receive. We believe that health plan resources devoted to improving patients’ health are properly categorized as medical rather than administrative costs.

If the final regulations fail to properly categorize these activities, it would increase costs for employers, and eliminate programs that are valuable to employees and beneficial to
their health. This would have a negative consequence on employees and their families, as well as the economic health of our state.

Thank you for this opportunity to comment on the proposed regulations.

Sincerely,

Christine A. Stearns

c: Thomas Considine, Commissioner
NJ Department of Banking and Insurance

Todd Sells, Director
Financial Regulatory Services
National Association of Insurance Commissioners
May 21, 2010

Mr. Lou Felice  
Chair, Health Care Reform Solvency Impact Subgroup

Mr. Steven Ostlund  
Chair, Accident & Health Working Group

National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, Missouri 64108

Dear Mr. Felice, Mr. Ostlund, and NAIC Subgroup Members:

On behalf of the 2,500 employer members of the Buffalo Niagara Partnership, I urge the National Association of Insurance Commissioners (NAIC) to recommend a broad definition of “quality improvement activities” related to the calculation of medical loss ratios (MLRs) under Section 2718 of the Patient Protection and Affordable Care Act (PPACA).

While the Partnership understands that the intent of the new MLR provision is to prevent insurers from spending too many premium dollars on administrative costs, we support the inclusion of a wide array of quality improvement activities including wellness programs, disease management programs, patient support systems, and health information technology tools.

Health plan providers must have the freedom to spend premium dollars on critical components of effective preventative health care including smoking cessation, counseling, fitness incentive programs, and the development of personal electronic medical records. Due to the importance of these value-added services, a “narrow” definition of quality improvement activities will adversely impact spending on vital health plan activities, increase costs for employers, and jeopardize valuable programs that can increase the health of our region’s workforce, and ultimately lower health care costs.

The Partnership encourages NAIC to develop a MLR calculation that includes a range of valuable services and tools ensuring that Buffalo Niagara employers can continue to offer high-quality health benefits to their employees.

Sincerely,

Andrew J. Rudnick
VIA Email Only
Mr. Lou Felice
Chair, Health Reform Solvency Impact Subgroup
c/o National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Re: Supplemental Health Care Exhibit

Dear Mr. Felice:

Thank you for the time you have invested in reviewing comments from all parties on the ongoing development of the Supplemental Health Care Exhibit. Wisconsin would appreciate the opportunity to comment on two points that were discussed during the subgroup calls this week.

The first paragraph of the current draft reads in part, "Expenses... that can be objectively measured and verified." During the open call this week a number of parties voiced concerns about the broadness of this language and the need to revise it to provide that any expenses included in quality have been objectively measured and verified. Wisconsin objects to this proposed revision. It is our belief that the referenced portion of the current draft definition is sufficient to provide regulators with the authority necessary to ensure that all expenses reported in the Expenses for Health Care Quality Improvements line are quantifiable. Early on in the development of a new quality improvement initiative, it may not be possible for a company to provide data to quantify the initiative's benefits. At this stage, it may be sufficient for a company to have a plan for objectively measuring and verifying the impact of the program as experience develops. Narrowing the definition to provide that expenses have already been quantified will place an unnecessary burden on insurers and serve as a roadblock to innovation.

Wisconsin would also like to comment on the definition of Part 1, Other Indicators, Line 3. Number of Groups. As a result of discussion that took place during the open call this week, the line was changed from Number of Plans to Number of Groups, and the definition was clarified to read, "This is the total number of groups issued as of the end of the reporting period." Our original understanding of the Number of Plans line was that it would indicate the number of different benefit plans aggregated in each column. This information would be very useful to us in understanding the data reported. We are unclear what benefit is added by requiring the reporting of Number of Groups. We encourage the subgroup to consider changing the line back to Number of Plans and defining it as follows: "The total number of different insurance policy forms or benefit plans in force as of the end of the reporting period" or, at a minimum, include a line for the number of plans along with the line for groups.

Thank you for considering our comments. We look forward to continued discussions of these issues.

Sincerely,

Richard A. Hinkel
Insurance Examiner Supervisor
Bureau of Financial Analysis and Examination
May 14, 2010

United States Department of Health and Human Services
Attention: DHHS-2010-MLR
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW.
Washington, DC 20201

Re: Public Comment on 45 CFR Parts 146 and 148; Medical Loss Ratios

Dear Secretary Sebelius:

We are writing in response to your request for information on the calculation of medical loss ratios (MLRs) as set forth in the Patient Protection and Affordable Care Act (PPACA). We were pleased with the PPACA’s inclusion of expenses for “activities that improve health care quality” in addition to “reimbursement for clinical services” as categories of health plan expenses that count toward meeting minimum MLRs. We respectfully request your assistance in assuring that activities relating to the prevention and management of chronic diseases are considered part of the value of benefits in the MLR calculation and not as administrative expenses.

To transform our health care system to one focused on protecting and promoting health rather than waiting to respond to illness, we must encourage both public and private sector health promotion and disease prevention efforts. Wellness and chronic care management programs have demonstrated improvements in health status and health outcomes, in adherence to treatment, in adoption of healthy behaviors, and in overall health care costs.

For example, the UPMC Health Plan has utilized a very successful practice-based care management system in which members of the plan with chronic conditions such as diabetes, congestive heart failure and depression have been assisted through care coordination and behavioral lifestyle support to better manage their chronic conditions. This has resulted in reduced expenditures in the total cost of care for these members and significant clinical improvements. An additional example where we believe that medical expenditures for prevention should be included in the MLR calculations is the work UPMC Health Plan has done with employers. We have seen significant improvement in smoking cessation rates, weight reduction and stress management that have all lead to improvements in productivity and improvements in cost trends. Another example would be our focused community health improvement activities such as work that we have performed with a county wide pediatric obesity program as well as a county-wide
diabetes prevention program. Both programs have proven to increase the health of the participants.

We must encourage the development, continuation, and broader adoption of such health improvement efforts, and preserve the flexibility needed to allow for continued innovation. Not allowing the expenses relating to these activities to count toward meeting minimum MLRs would be a significant deterrent and should be avoided.

We urge you to count the costs associated with programs, measures, or activities designed to achieve one or more of the following goals as part of the value of benefits in the medical loss ratio calculation:

wellness, health promotion, or fitness;

prevention of chronic disease onset or progression;

improvement of health outcomes through disease or chronic care management, managing care transitions, patient or family caregiver education and self-management support, or medication adherence or other care management compliance efforts;

Care coordination; or

patient safety or reducing medical errors.

Addressing the burden of chronic disease in a meaningful, sustainable way requires that implementation policies encourage both public and private dedication to health improvement efforts. Incorporating expenses relating to the health improvement goals described above as part of the value of benefits in the calculation of MLRs is an important step forward in encouraging these efforts.

Sincerely,

Daniel B. Vukmer, Esquire
Vice President & General Counsel

cc: Lou Felice, Chair Health Reform Solvency Impact Subgroup
    Joel Ario, Pennsylvania Insurance Commissioner