EQUAL Health Network ◆ *Equitable Quality Universal Affordable*

HEALTH INSURANCE REGULATIONS SHOULD BENEFIT THE PUBLIC

Comments on NAIC Draft. 9/23/10:
REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZED REBATE CALCULATION METHODOLOGY FOR PLAN YEARS 2011, 2012 AND 2013 PER SECTION 2718 (b) OF THE PUBLIC HEALTH SERVICE ACT

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Attention: Eric King, NAIC, at EKing@naic.org and John Engelhardt, NAIC, at JEngelha@naic.org
Copy to: The Honorable Kathleen Sebelius, Secretary, Department of Health and Human Services; Jay Angoff, Steven Larsen, OCIIO, HHS

The Affordable Care Act (ACA) empowers the Secretary of the Department of Health and Human Services (HHS) to implement the law in a way that benefits the public. On the key issue of Medical Loss Ratios (MLR), the law requires health insurance companies to spend at least a minimum percent of premium dollars on the medical claims of subscribers. Companies that fail this test must provide rebates to subscribers. The intent of imposing the MLR is to "bring down the cost of health care coverage" and "ensure that consumers receive value for their premium payments." It should provide incentives to the health insurance industry to operate efficiently and negotiate assertively with health care providers, rather than simply passing on cost increases to consumers.

Companies can frustrate the intent of the law by defining medical claims to include other expenses, including marketing expenses typically considered part of administration.

The National Association of Insurance Commissioners (NAIC) approved proposed regulations to define the MLR on August 17, 2010. A revised draft dated September 23, 2010, will be reviewed by the NAIC on Monday, Oct. 4, and will go from there to the "B" Committee of NAIC. When completed the proposal will be subject to certification by the Secretary of HHS.

The current proposal would count "Activities that increase the likelihood of desired health outcomes," and specifically "Public health education campaigns that are performed in conjunction with state or local health departments," as medical expenses rather than administrative expenses. [1] [2] **This standard goes beyond the law (ACA Section 2718), and opens an entirely new category of expenses that insurance companies can rely on to justify reduced spending on care for subscribers, and thus denials of care. It will frustrate the aims of the law and instead give undue weight to the views and interests of the insurance industry. We urge the NAIC to strike this section.**

[1] See items listed as Quality Improvement activities in Column 4 of the "Expenses to Improve Health Care Quality: Derived from Supplemental Health Care Exhibit - Part 3," beginning on page 26 of the 9/23/10 draft.
[2] A review of states' rules on MLR, compiled by the National Association of Insurance Commissioners (NAIC) and published by America's Health Insurance Plans (AHIP), shows that most states do not use this definition, and define administrative expenses straightforwardly. State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations (as of April 15, 2010). AHIP.

In the event that this section is retained, we urge removing the sentence referring to state or local health departments, and replacing it with**: "Public health education campaigns implemented by state or local health departments whose costs are covered by the insurance industry and which relate to the improvement of population health and are non-proprietary."**

We further ask HHS to establish a transparent and accountable system for soliciting the public's comments on the proposed regulations, as part of the process of certifying these proposals.

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

The ACA calls for a Medical Loss Ratio That Controls Costs, Provides Value

The success of the minimum MLR depends largely on how it is defined. The MLR is a ratio, with all medical claims (in the numerator) divided by total income (in the denominator). Section 2718 of the ACA establishes a minimum MLR that requires health insurance companies in the large market to spend at least 85% of premiums on patient care, and no more than 15% on administration and profit. In the small group/individual market, the figures are 80% for claims and 20% for administration and profit. To fairly achieve an 85% MLR, a company would have to show that the amount spent on medical claims (in the numerator) is high relative to premiums. A high MLR generally means that the insurance company is spending a relatively higher share of premium income on its members' medical care and less for administration and profit. A low MLR means that the insurance company is returning less in medical care benefits to its members while retaining more for executives and shareholders. This can also signal a solid opportunity for investors.

"Activities That Increase the Likelihood of Desired Health Outcomes:" An Invitation to Game the System

Section 2718 of the ACA counts clinical services (2718 (a)(1)) and activities that improve health care quality (2718 (a) (2)) as part of the numerator of the MLR, while non-claims costs (2718(a)(3)) reside on the administration side, in the denominator. The ACA standard for including an expenditure for non-clinical care as a medical expense is that it must "improve health care quality." This standard carefully does not include activities that insurers claim will improve the health of the public generally. This is known to be the province of public health departments.

However, the NAIC draft standard further tilts the definition to the industry's advantage by including in the MLR "Quality Improvement" programs, widely defined as "activities that increase the likelihood of desired health outcomes." The NAIC adds that such programs should be "capable of being objectively measured and of producing verifiable results and achievements."

This provision is an open invitation to the industry to "game" the system by characterizing marketing programs as wellness campaigns. The insurance industry has already stated its intention to game the

system by raising premiums to make up for any constraints imposed by the new law,[3] and has begun to manipulate the MLR rules for its own gain.[4] The Senate Commerce Committee has documented that, "At least one company, WellPoint, has already 'reclassified' more than half a billion dollars of administrative expenses as medical expenses, and a leading industry analyst recently released a report explaining how the new law gives for-profit insurers a powerful new incentive to 'MLR shift' their previously identified administrative expenses."[5]

Classic Mismatch: Individual Premiums and the Public's Health

The NAIC's draft additionally defines the MLR to the industry's advantage by counting "Public health education campaigns that are performed in conjunction with state or local health departments," as medical expenses rather than administrative expenses. [6] (See Appendix I for the sections directly relevant to public health departments.)

This proposal presents a classic mismatch of policies and purposes. The intent of the MLR is to assure that individual subscribers receive the medical care they pay for through premiums, and to reduce the incentives for insurance companies to unfairly deny claims while diverting premiums into administrative expenses such as marketing and executive compensation. These individual subscribers stand to receive rebates if the MLR ratio is not achieved.

Public health departments, in contrast, are funded by the public, and their programs are not targeted or limited to any commercially defined subset of the population. A wellness campaign involving insurance companies and health departments could contribute to improved health of the community generally, including people who do not pay premiums to the company. This possibly worthy purpose is not the intended use of the subscribers' premiums, or of the numerator of the MLR, which is to assure that individual subscribers get their medical benefits, and measures direct benefits specifically to subscribers.

As the NAIC draft notes, "**The expenses must be directed toward individual enrollees** or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self insured

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[3] Judy Dugan, Jerry Flanagan, Carmen Balber. Comments from Consumer Watchdog to NAIC on medical loss ratio rulemaking per Section 2718 of PPACA, May 10, 2010.

[4] Noam Levey. *Lawmakers in most states have little control over healthcare premiums*. LA Times, August 12, 2010. "A review of campaign donations shows insurers funneling money to key lawmakers and squelching efforts to expand oversight of premiums."

[5] Committee On Commerce, Science, And Transportation, Office Of Oversight And Investigations, Majority Staff. Implementing Health Insurance Reform: New Medical Loss Ratio Information For Policymakers and Consumers. Staff Report for Chairman Rockefeller April 15, 2010. http://commerce.senate.gov/public/?a=Files.Serve&File_id=d20644bc-6ed2-4d5a-8062-138025b998ef

[6] A review of states' rules on MLR, compiled by the National Association of Insurance Commissioners (NAIC) and published by America's Health Insurance Plans (AHIP), shows that most states do not use this definition, and define administrative expenses straightforwardly. State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations (as of April 15, 2010). AHIP.

plans." In fact, such optional activities could raise premiums, or require additional administrative effort to determine whether or not the activity is legitimate.

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

Give Public Health Departments the Authority They Merit

The proposal asks public health officials to collaborate in initiatives that will be in effect proprietary, but legitimized by their participation. If the approved regulations placed the content and substance of these campaigns under health department authority, paid for and subsidized by the insurance industry, the programs would be more likely to meet the test of actually improving health outcomes. A better provision would read:

> **"Public health education campaigns implemented by state or local health departments whose costs are covered by the insurance industry and which relate to the improvement of population health and are non-proprietary."**

MLR Should Be Defined Narrowly

Regulatory standards defining costs of care and quality improvement are important. An MLR of 85% is already lenient towards insurance companies. An array of health insurers that are highly rated for quality regularly attain medical loss ratios of 90 percent or more. (For example, major non-profit Massachusetts insurers often achieve and exceed that threshold; in recent years, Fallon, Harvard Pilgrim, and Tufts HMO have annually spent 87-91 percent of their premiums on care.)

The ACA standard applies only to insurers' revenues from premiums. Yet patients and payors should be equally concerned about how an insurer uses income from its investment of the sums it extracted from previous years' patient premiums. A more appropriate standard would measure the share of insurers' total revenues devoted to care, as some analysts have urged.[7]

Given these factors, it is vital that the "medical" and "quality improvement" portion of insurance expenditures be defined strictly, and that standardized reporting requirements be detailed to prevent miscategorization of administrative expenses.

A process for public comment on the proposed regulations will offer the groundwork for constructive and equitable adjustments to the rules.

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7 Alan Sager and Deborah Socolar, "A Better Deal for Our Health Care Dollars: Testimony to the Joint Committee on Insurance, Massachusetts General Court, on H. 1208, An Act to Promote the Efficient Use of Health Care Revenues," Health Reform Program, Boston University School of Public Health, April 2, 2001, http://dcc2.bumc.bu.edu/hs/sager/A%20Better%20Deal%202%20Apr%2001.pdf;
Robert Padgug, Rekindling Reform, testimony at state health reform hearings, 30 October 2007, partnership4coverage.ny.gov/hearings/2007-10-30/testimony/docs/robert_padgug_-_rekindling_reform.pdf

APPENDIX I: FROM NAIC "BLANK"

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3

Part A of this exhibit is intended to provide disclosure of expenses by major type of activity that improves health care quality, as defined below, as well as the amount of those expenses that is used for other activities, and reported separately for the Individual, Small Group and Large Group amounts.

Improving Health Care Quality Expenses – General Definition:

Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements. **The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self insured plans.** Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations. They should not be designed primarily to control or contain cost, although they may have cost reducing or cost neutral benefits as long as the primary focus is to improve quality. Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the PPACA:

Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;

Prevent hospital readmissions;

Improve patient safety and reduce medical errors, lower infection and mortality rates;

Increase wellness and promote health activities; or

Enhance the use of health care data to improve quality, transparency, and outcomes.

NOTE: Expenses which otherwise meet the definitions for QI but which were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.

Column 4 – Wellness & Health Promotion Activities

Expenses for programs that provide wellness and health promotion activity as defined above (e.g., face-to-face, telephonic or web-based interactions or other forms of communication), including:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
- Public health education campaigns that are performed in conjunction with state or local health departments;
- Actual rewards/incentives/bonuses/reductions in copays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI with the following restrictions:
    - Only allowed for small and large employer groups, not individual business; and the expense amount is limited to the same percentage as the HIPAA incentive amount limit;
- Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;
- Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); and

Health information technology expenses to support these activities (Report in Column 5 – See instructions).

APPENDIX II: Section 2718, PPACA

21 PPACA (Consolidated) Sec. 1001\2718 PHSA

''SEC. 2718 ○42 U.S.C. 300gg–18. . BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

[Replaced by section 10101(f).

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

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

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

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

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

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

''(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—

''(A) REQUIREMENT.—Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)),is less than—

''(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

''(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.

''(B) REBATE AMOUNT.—

''(i) CALCULATION OF AMOUNT.—The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

''(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

''(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

''(ii) CALCULATION BASED ON AVERAGE RATIO.—Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

''(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

''(3) ENFORCEMENT.—The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

''(c) DEFINITIONS.—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and 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). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

''(d) ADJUSTMENTS.—The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.