EQUAL Health Network ◆ *Equitable Quality Universal Affordable*

PUBLIC HEALTH TO HHS, NAIC: REGULATIONS FOR INSURANCE SHOULD BENEFIT THE PUBLIC

August 16, 2010

TO: The Honorable Kathleen Sebelius, Secretary, Department of Health and Human Services
Attn: Brian Webb, NAIC, bwebb@naic.org and cavila@naic.org

The Affordable Care Act (ACA) empowers the Secretary to implement the law in a way that benefits the public. The National Association of Insurance Commissioners (NAIC) is set to approve proposed regulations on August 17, which will then be subject to your approval, on the key issue of Medical Loss Ratios. **We are concerned that the standards now proposed by the NAIC will frustrate the aims of the law and instead give undue weight to the views and interests of the insurance industry.[1] As public health professionals and leaders, we urge you to critically review and modify the NAIC's proposals to HHS in ways that best assure affordable and accessible health insurance.**

Section 2718 of the ACA establishes minimum Medical Loss Ratios (MLR) to "bring down the cost of health care coverage" and "ensure that consumers receive value for their premium payments." It requires health insurance companies in the large market to spend at least 85% of premiums on patient care, and only 15% on administration and profit. In the small group/individual market, the figures are 80% MLR and 20% for administration and profit.

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

The NAIC proposal would allow the insurance industry to count marketing campaigns performed in conjunction with state and local public health departments as medical expenses. This reference appears in the Medical Loss Ratio (MLR) "Blanks" proposal by the Financial Condition (E) Committee of the NAIC dated June 29, 2010. **We consider this proposal an avenue to inflate charges unduly, and ask you not to accept it. It is urgent that**

1 Noam Levey "Lawmakers in most states have little control over healthcare premiums: Only 19 states have 'prior approval' authority over insurance rates. A review of campaign donations shows insurers funneling money to key lawmakers and squelching efforts to expand oversight of premiums" LA Times, August 12, 2010
a http://www.latimes.com/health/healthcare/la-fi-healthcare-states-20100812,0,786534.story

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you make it clear that you will act in the public's interest, not the insurance industry's or Wall Street's.

We offer these comments in the hope that the NAIC will more equitably balance the interests of the public and of the insurance industry, and we further ask that you, Madame Secretary, make an independent assessment of the NAIC's recommendations. The agency has established an effective track record of responding to and rectifying insurance industry abuses. We appreciate your personal commitment to protecting and advancing the public's interest in access to affordable health care.

We focus in this letter on aspects of the MLR that directly reference public health. We are aware that the NAIC is discussing other issues of concern to public health, including the treatment of taxes in calculating the MLR, and standards for consumer information.

The EQUAL Health Network brings together nationally partners 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.

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

The intent of imposing a minimum MLR is to help to set affordable premiums and bring down health care costs. It is meant to 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.

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

Defining "Activities That Improve Health Care Quality:" Distinct from Public Health

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

This allows companies to count among the 80 - 85% spent on medical care "activities that improve health care quality" as a component of the MLR. **The insurance industry's proposals ask the NAIC to define the MLR to its advantage by counting marketing programs, including those with public health themes, as medical expenses rather than the**

administrative expenses they clearly are. [2] This is an open invitation to the industry to "game" the system.

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

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

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

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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.

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 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

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

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

MLR Should Be Defined Narrowly

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

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.[5]

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.

Continuous Monitoring, and Involvement of Patients and Advocates

It is vital that rate review and other pressures be strong enough to prevent insurers from simply raising premiums in order to offset the limit on their administration/profit share. It will also be important to create an ongoing process to set and review the initial regulations which are required to begin in September, 2010. Public comment on this system's achievements and

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5 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

limitations will provide important assessments of the system's success and offer the groundwork for constructive and equitable adjustments to the rules.

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