AMA
AMERICAN
MEDICAL
ASSOCIATION

June 30, 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

Dear Mr. Felice:

On behalf of the physician and medical student members of the American Medical Association (AMA), thank you for this opportunity to provide the National Association of Insurance Commissioners (NAIC) with comments and recommendations in response to the NAIC Blanks (E) Working Group, Blanks Agenda Item Submission Form.

The AMA has reviewed your June 23, 2010 recommendations. We commend the efforts that your committee has made to promote transparency in the health insurance reporting process. We are very pleased to see that the committee has revised the proposal to reflect the statutorily listed quality improvement categories, as we requested in our June 7, 2010 letter. Maintaining a clear division between quality versus administrative costs and cost containment under the Patient Protection and Affordable Care Act ("ACA") is essential to ensure that health insurers are spending an appropriate percentage of premium dollars on direct patient care and activities designed to improve individual patients' health. However, we remain concerned that in many proposal provisions there appears to be a presumption that an expenditure is quality improvement when in fact it is more likely that it is for cost containment or other administrative purposes. We believe that this presumption should be reversed. Specifically, we recommend that any expenditures which could be characterized as "administrative" or "cost containment" *not* be included in the quality improvement category.

Towards the goals of ensuring that the final medical loss ratio regulation reflects the statutory intent of ACA- that patients receive the maximum for the premium dollars spent- we offer the following recommendations for consideration.

Strongly Oppose Alternative Option For Handling Other Quality Improvement Expenses

The AMA strongly opposes the new "Alternative Option for Handling Other QI Expenses." We urge you to remove the entire "alternative" and instead, include relevant provisions from the "alternative" in the actual proposal, where statutorily appropriate. We oppose the "alternative"

because it includes inappropriate exclusionary language that health insurers can broadly interpret to include expenses that do not meet the statutory requirement of "improving health outcomes, preventing hospital readmissions, improving patient safety and reducing medical errors or promoting health and wellness." We have great concerns about incorrectly including categories like "fraud prevention services," "network management," "provider contracting and credentialing costs," "accreditation fees" and any other broad categories in the numerator of the medical loss ratio calculation. These activities are not quality improvement. To the contrary, we believe that many of these activities are simply "the cost of doing business." If an insurer wants to offer a health insurance product, then it must pay for the cost of doing business and not miscategorize them as "quality" when they have no nexus to improving patient benefit. We urge you to explicitly exclude the following activities from ever being considered quality improvement for the reasons provided below:

- Retrospective and concurrent utilization review activities are designed to detect and eliminate primarily overuse and inappropriate use of services. This is a cost containment expense.

- Twenty-four hour health professional hotlines are designed to avoid unnecessary physician visits and to help ensure that patients in need urgent care receive it so a problem does not escalate into a larger more expensive problem. This expense decreases the cost of care.

- Fraud prevention is a regulatory expense that is part of the "cost of doing business."

- Network access and management fees are related to the cost of developing and executing provider contracts and fees. These administrative expenses are necessary for establishing or managing a provider network. If an insurer wants to offer a consumer product, it must pay for the cost of offering a viable managed care product. This expense ensures that enrollees have access to adequate physicians, providers and facilities to receive the value of the medical care they pay for through their insurance premium.

- Accreditation is a health insurer business expense that fulfills their contract obligations with payers. This is an administrative expense.

- Provider credentialing protects health insurers from liability risks associated with contracting with unqualified providers of care. This is an administrative expense.

As described above, the "alternative" creates great latitude for health insurers to creatively categorize many expenses that have long been defined and considered to be administrative costs

as quality improvement. We urge you to expressly exclude these costs from any calculation of "quality improvement." We respectfully request that the committee eliminate this alternative and use the current "Supplemental Health Care Exhibit- Part 3," with our changes added.

Health Information Technology

The AMA agrees that utilization of health information technology is an important tool in the development of many quality of care improvement initiatives. We appreciate that health insurers have made large investments in health information technology and understand how integration improves efficiency, care and quality.

However, we have significant concerns about how these investments are accounted for in your proposal. As discussed in our June 7, 2010 letter, we disagree with the committee's interpretation that Section 2717 of ACA provides adequate authority for the committee to include health information technology expenses as part of the statutorily defined four categories of quality improvement. There is no evidence that Congress had any intention of including health information technology in any category but the improvement of patient safety and reduction of medical errors. Our concerns are particularly heightened by the section, "Exclude," under Column 5, "HIT Expenses for Health Care Quality Improvement." This language suggests that the only computerization costs which will not be considered a quality improvement expense will be those costs associated with claims adjudication systems. Health insurers already have substantial computerization expenditures associated with utilization review, fraud and abuse, credentialing, contracting, etc.

We urge the committee to eliminate the entire Column 5, "HIT Expenses for Health Care Quality Improvements," because there is no statutory authority for this section. Column 5 has significant potential to be broadly misinterpreted and abused by health insurers, allowing them to broadly categorize many expenses that have no nexus to direct patient benefit as "improving quality" and thus part of the medical expense ratio.

We also urge the committee to remove the newly added category of "Enhance the use of health care data to improve quality, transparency and outcomes" from the introductory language of Part 3. There is no statutory basis for this newly added category, which like HIT, is a means, not an end to improve quality. We respectfully request that the committee only address the four clearly defined "quality improvement" categories as defined in Section 2717.

If you believe you must include health information technology expenses in the quality improvement section, then we strongly urge you to remove the current Column 5, and instead, retain the current health information technology provisions that are integrated under the expense

lists of the four statutorily defined quality improvement categories of Section 2717. We urge the committee to require that any health information technology related expenses that are reported on the form are also accompanied with a clear written justification from the health insurer showing objective, evidence-based documentation of how the expense will directly benefit patients in conjunction with one of the four statutorily authorized quality improvement goals.

Medical Incentives Pools and Bonuses

We respectfully request that the committee revise Supplemental Health Care Exhibit, Part 2, Line 2.8, "Incurred Medical Incentive Pools and Bonuses." As discussed in our May 17, 2010 letter, we believe that physicians should receive appropriate bonuses and that their reimbursement structure must be fair. All money paid to health care providers should be included as a "medical expense," regardless of whether it is denominated as a fee-for-service payment, a "pay-for-performance" bonus or any other payment for quality or efficiency enhancing initiatives, a "shared savings" amount, a per member/per month fee, a bundled payment, etc. There is currently much discussion about new payment models for physicians, and it is unclear what will emerge. We do not think this regulation should be structured to provide any incentive to insurers to chose one form of payment over another. Thus, we would eliminate the separate line for "Incurred Medical Incentive Pools and Bonuses," and include those amounts under "Claims." We would also define the term much more broadly, to include any type of quality or efficiency enhancing initiative.

Increasing Transparency of Expenses that Improve Quality

We strongly encourage you to require the reporting of "quality improvement expenses" by their relevant subcategories, as you require for other expenses. These expenses should be broken out to indicate all of the following: salaries, outsourced services, EDP equipment and software, other equipment (excluding EDP), other expenses. If HIT is to be included in each of the four categories, then there should be a line for that as well. See discussion below.

The AMA urges the committee to revise Supplemental Health Care Exhibit Part 3, Chart 3B "Quality Improvement Expenses Only," to reflect similar categories as those listed in Chart 3A. One of the most important reasons for requiring health insurers to follow a medical loss ratio is to ensure that enough premium dollars are being spent on direct medical care. In an effort to promote consistency and consumer understandability, we urge the committee to use the same expenditure criteria used for quality improvement that is used in Chart 3A in Chart 3B. For Chart 3B, we recommend that salaries, outsourced services, EDP equipment and software, other equipment (excluding EDP), and other expenses be listed separately, and under "HIT expenses"

categories. In addition to including a mechanism in the chart that will ensure double counting does not occur, we also urge the committee to draft strong enforcement language setting rigorous penalties against insurers who attempt to illegally account for expenses, for example, double counting of quality improvement costs.

Conclusion

The AMA appreciates the opportunity to provide its comments about medical loss ratios to NAIC. We look forward to working further with NAIC and HHS on this important matter. Should you have any questions regarding these comments, please contact me at elizabeth.schumacher@ama-assn.org or (312) 464-4783 for more information.

Sincerely,

Elizabeth A Schumacher

Elizabeth A. Schumacher
Legislative Attorney
Advocacy Resource Center