



May 17, 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), I appreciate the 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. During the health care reform debate, the AMA repeatedly expressed support for establishing greater transparency in the health insurance market. Health insurance is too expensive and important to be confusing. Premium transparency and medical loss ratio information is extremely valuable for patients. The AMA supports patients receiving the maximum value for the premium they pay. Mandating premium transparency is an important step toward controlling spiraling health care costs, which are due, in part, to the dramatic rise in administrative costs and insurer profits.

The AMA has studied the issues of premium transparency and medical loss ratios in great detail. In January of 2009, we introduced model state legislation entitled the "Health Insurance Premium Transparency Act" to our component medical associations and physician members. In order to ensure that the model legislation reflected industry best practices and would not be unduly burdensome, we worked closely with a health insurance actuary when writing this and all of our related model bills. By simply making public the work that health plan actuaries already perform to set the premiums of each health plan in a standardized "Premium Transparency Report," the model legislation establishes a regulatory approach that would greatly enhance transparency and accountability in the pricing of health insurance premiums, while at the same time not imposing an undue burden on health insurers.

The AMA has reviewed your final recommendations of May 12, 2010. We commend the efforts that your committee has made to promote health insurance transparency. We further commend your committee's sensitivity to the potential health insurers will attempt to shift expenses that have long been categorized as "cost containment" expenses to the "quality improvement" side of the ledger which, under PPACA, will be counted in the numerator along with payments for medical services in the medical loss calculation.

Transparency at the health insurance product level

As detailed in the AMA's May 13, 2010 response to Secretary Sebelius' request for comments on Section 2718 of the Public Health Services (attached), we respectfully request that your committee go even farther on multiple fronts. With respect to transparency, if consumers of health insurance are to be empowered with the information necessary to make informed purchasing decisions, it is imperative that full information be available at the level at which these decisions must be made – the health insurance product. We understand your recommendation to require reporting for each of six categories of insurance sold in each state (with a seventh placeholder category). We certainly think your proposal is far superior to proposals which would have allowed further aggregation of products and/or territories. It may also be the case that for administrative reasons, this is the most discrete level at which it is administratively feasible to compute and enforce the rebate requirement. However, even if it is not possible to provide for rebates at the individual product level, we urge you to require reporting at the product level. Health insurers have this information at the product level as they must use it to set the premium. Without this information, consumers will not have the information they need to make informed choices, and to health insurers may be rewarded when they maximize expenditures on those things the consumer finds to be most valuable.

More precise definition of quality

With respect to defining “activities to improve health care quality,” we would urge a narrower and more precise definition.¹ Specifically, we recommend the following:

For the purposes of this section, “activities that improve health care quality,” are defined to include the actual cost incurred by the health insurance issuer of direct services and educational materials provided to patients and health care providers designed primarily to maintain or improve the overall health status of the health plan's subscribers.

- This definition does not include any other expenditures, including but not limited to those associated with the costs of: (1) quality assurance programs; (2) utilization review and management; (3) pharmacy or other

¹ We note that there seems to be a big difference between what is included in the descriptions of Lines 5.1 and 5.2, and what is included on the forms. We also note that Part 3, Supplemental Health Care Exhibit, seems to have been misformatted so that the expenses are not reported by product line, as they are for all other expenditures. If this was not a mistake, we strongly disagree with the proposed chart, as it would appear to permit aggregation across all product lines, and allow the inclusion of many activities which clearly have cost containment as their principle purpose.

benefit management; (4) network contracting and management; (5) fraud and abuse programs; (6) state and federal regulatory compliance; (7) administrative, data management and profiling activities that support, but are not an actual component of, the provision of patient or physician educational materials and services designed primarily to maintain or improve the overall health status of the health insurer's subscribers (which educational materials and services are accounted for under the heading "Activities that improve health care quality") or payments to health care providers for pay-for-performance or other quality or efficiency enhancing initiatives (which payments are accounted for as a "medical expense"); (8) development of clinical health policies; and (9) any home office or other overhead costs associated with either "medical expenses" or "activities that improve health care quality."

- This definition also does not include any of the other expenditures listed below as an "administrative expense" section of the "Premium Transparency Report" described below.²

As we emphasize in our letter to Secretary Sebelius, the AMA remains firmly committed to quality improvement efforts, and ensuring that regulations governing medical loss ratios not improperly chill appropriate efforts by health insurers to engage in such efforts. At the same time, we understand that the term "quality improvement" is subject to widely varying definitions, and we are concerned that patients and other health care consumers not be misled into equating expenditures on "quality improvement" with expenditures on direct services. We are also very concerned about recent efforts by the health insurance industry related to medical loss ratios to "reclassify" administrative expenses and otherwise promote "creative accounting." For example, according to one source, America's Health Insurance Plans (AHIP) recently urged its members to notify NAIC that fraud and abuse reduction activities may be considered "activities that improve health care quality" for the purpose of calculating medical loss ratios under PPACA.³ While the AMA abhors fraud and fully supports appropriate efforts to ferret out fraud and abuse, this is a quintessential administrative activity.

For these reasons, we strongly recommend that expenditures on direct medical services be disclosed separately from expenditures on "quality improvement activities." Further, we recommend that the definition of "quality improvement activities" be narrowly defined to include only expenditures that are unambiguously identifiable. Specifically, in the definition above, we include only the actual costs incurred by the health insurance issuer on direct services and educational materials provided to patients and health care providers designed primarily to maintain or improve the overall health status of the health plan's subscribers. We believe it is

² For an example of a state law that exempts similar costs from its medical loss calculations, see 28 Texas Administrative Code section 3.3307.

³ "AHIP Urges Members To Reach Out To State Insurance Commissioners On MLR," May 7, 2010, A. Lotven, InsideHealthPolicy.com.

important to focus on the purpose of these expenditures, rather than the name that a particular health insurer may use to categorize them. In particular, those initiatives which are truly designed primarily to improve or maintain the health status of patients should be distinguished from those that, while using a "quality improvement" rubric, are fundamentally an effort to achieve program savings. In this regard, we note that NAIC has long identified much of what is now included in the committee's proposed definition of "quality improvement" as a "Cost containment" expense⁴.

While we understand that some health insurers have suggested that this approach may create some disincentive to health insurer investment in quality improvement activities, we believe that risk will be low given the return on appropriate quality improvement investments in both increased efficiency and reputation. On the other hand, the risk that a broader definition will be applied differently by different health insurers is high, and such variability would undermine the ability of health insurance purchasers to shop comparatively. Finally, as noted above, a broader definition also raises a significant risk that at least some health insurance issuers will game the system.

We note that your committee has also suggested that health insurers be able to report "health information technology expenses related to health improvement" as a quality improvement activity. The AMA strongly supports the development of appropriately constructed health information exchanges, and constructive efforts by health insurers to share clinical effectiveness information with physicians and other health care providers for the purpose of improving the quality of care patients receive. As a general matter, we believe health information exchanges need to be established at the regional level, rather than at the level of individual health insurance companies. We are also concerned as to what is intended by the distinction between what is included in the first bullet and the third bullet in line 5.2. We do not believe that profiling activities at the individual physician level belong in this expense. In addition, for the reasons described above, we do not believe it is appropriate to include "personnel costs" or other ambiguous expenses which may be expanded to included overhead costs in this category.

⁴ See Claims, Losses and Loss Adjustment Expenses, *defining cost containment expenses to include:*

Expenses that actually serve to reduce the number of health services provided or the cost of such services. The following are examples of items that shall be considered "cost containment expenses" only if they result in reduced levels of costs or services: *i. Case management activities; ii. Utilization review; iii. Detection and prevention of payment for fraudulent requests for reimbursement; iv. 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; v. Consumer education solely relating to health improvement and relying on the direct involvement of health personnel (this would include smoking cessation and disease management programs, and other programs that involve hands on medical education); and vi. Expenses for internal and external appeals processes.*

Mr. Lou Felice
May 17, 2010
Page 5

Finally, as noted in our definition of “activities that improve health care quality,” we believe that all money paid to health care providers should be included as “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 choose one form of payment over another. Thus, we would eliminate the separate line for “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.

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
Legislative Attorney
Advocacy Resource Center

Enclosure: AMA comments and attachments to Secretary Sebelius, May 13, 2010