August 5, 2010

NAIC Executive Committee

Re: Medical Loss Ratio Blanks Proposal

Dear Committee Member:

The undersigned appreciate the opportunity to provide the National Association of Insurance Commissioners (NAIC) with comments and recommendations regarding the medical loss ratio blanks proposal ("proposal"). There is a great need for establishing transparency in the health insurance market. Health insurance is too expensive and important to be confusing. Medical loss ratio information is extremely valuable for patients. We support patients receiving the maximum value for the premium that they pay and receiving complete information on how their premium dollars are spent.

We commend the NAIC on the proposal process. To reach the current comprehensive proposal and definitions, the NAIC's Health Reform Insolvency (E) Impact Subgroup ("Subgroup") employed an inclusive and transparent process that provided many opportunities for all stakeholders to provide input. With the exception of the most recent edits to the proposal which we believe need further refinement, the proposal reflects a fair outcome that furthers the goal of the Patient Protection and Affordable Care Act ("Act"): to protect consumers by ensuring set levels of premium dollars are spent on their medical care. We believe that with the changes set forth below, this balanced compromise of multi-stakeholder interests, reflected in the proposal, should be adopted.

Quality Improvement

We commend the NAIC for developing a proposal that properly limits "quality improvement" to those activities that promote measurable, direct patient benefit. We urge you to recognize and support the clear distinction between "quality assurance," an activity that has long been understood to be an administrative expense, and "quality improvement" expenses which will count toward minimum medical loss ratio levels. The Act indicates that only expenses related to "health care quality improvement" should be counted as medical expenses when determining

whether a health plan meets the newly mandated minimum medical loss ratio percentages. The "quality assurance" versus "quality improvement" categories are, and should be kept, separate for medical loss ratio purposes. "Quality improvement" expenses should include only those costs designed to improve health care quality by producing desired patient outcomes that can be objectively measured and verified. This category should not include costs that focus on improving the quality of the insurance plan itself or activities related to cost containment that benefits the insurance plan.

To that end, and contrary to the most recent version of the proposal, we urge you to exclude from the health care quality improvement category all utilization review activity, whether it be done prospectively, concurrently or retrospectively. Utilization review is the quintessential managed care cost containment strategy. It has nothing to do with "quality improvement." We also urge you to remove the sentence recently added under the "Expense Allocation Supplemental Filing" on page 18 of the proposal, which directs that expenses for prospective utilization review (as well as the costs of rewards or bonuses associated with wellness and health promotion) be included in the "E" column. With respect to "the costs of rewards or bonuses associated with wellness and health promotion," we believe these should more properly be included with the other "pay for performance" and shared savings payments listed in the prior section of the proposal.

With that one change, we believe the proposal will reflect a reasonable compromise as to those activities which should be defined as "quality improvement." With the limited exception noted in the proposal, all utilization review, health professional hotlines, all fraud prevention and related activities, network access and management fees, accreditation and provider credentialing must be excluded from the definition of "quality improvement." All of these expenses are administrative and should never be considered quality improvement as they do not improve the quality of care for individual patients in objective and verifiable ways.

We also support the ability for the NAIC to revisit the categorization of costs for medical loss ratio purposes once we have had experience with these definitions, including whether a currently excluded cost should be included and whether an included cost should be excluded. The second "Note" included on page 18 of the proposal (located under the "exclusion" category) should be revised to provide for a two-way deliberative process for future analysis.

Fraud Expenses

We strongly support the subgroup's decision not to include expenses incurred in conjunction with programs designed to find and eliminate fraud and abuse in the "quality improvement" category. While we agree that health insurers should be able to offset the costs of these programs against recoveries which are applied to reduce claims expenditures, we believe two further clarifications are necessary. First, we believe it is important to define what types of expenditures are to be considered "fraud and

abuse expenses," so that unrelated administrative expenses are not improperly shifted to this category. Second, we have concerns about the timing of when fraud recoveries are applied in the medical loss ratio calculation. For example, a claim incurred and paid in one year may be discovered fraudulent the following year. In order to ensure that fraud activities and recoveries are accurately documented and applied, the proposal should include a section documenting when the claim was incurred, and require that any applicable fraud recovery be applied in the year that the fraud was recovered-regardless of when the claim was incurred. Similarly, the associated expenses with that recovery should be attributed to the year in which the recovery is made.

Conclusion

Thank you for your consideration of our views on medical loss ratios and the transparency of spending of health insurance premiums. Please feel free to contact Elizabeth Schumacher, American Medical Association, at elizabeth.schumacher@ama-assn.org, Jeff Micklos, Federation of American Hospitals, at jmicklos@fah.org or Molly Collins Offner, American Hospital Association, at mcollins@aha.org.

Sincerely,

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