United States Senate

COMMITTEE ON COMMERCE, SCIENCE,
AND TRANSPORTATION

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July 20, 2010

Commissioner Jane L. Cline
President
National Association of
Insurance Commissioners
2301 McGee Street
Suite 800
Kansas City, MO 64108-2662

Dear Commissioner Cline:

For the past few months, the National Association of Insurance Commissioners (NAIC) has been conducting a series of meetings to develop the uniform standards and definitions necessary for the implementation of the new law establishing minimum medical loss ratios in the commercial health insurance market. My staff and I have followed these proceedings closely because the medical loss ratio requirement is one of the most important consumer protection provisions included in the health care reform legislation that President Obama signed into law in March.

While I have several concerns about medical loss ratio implementation that I will address in this letter, I want to first commend the NAIC staff and working group leaders for creating a fair, deliberative process that has allowed interested parties to share their comments and ideas about how this important new law will take effect. Although their work is not yet finalized, the working groups have developed a basic framework that both addresses the financial implications the new law may have for health insurance companies, and requires insurers to demonstrate in measurable, verifiable ways that they are spending larger portions of each premium dollar on patient care.

My biggest concern about this process remains the one I expressed in the letter I sent you on May 7, 2010 – it is clear that health insurance companies are sparing no expense to weaken this new law and the protection it promises to America's consumers.[1] Health insurance companies and their allies have been furiously lobbying the NAIC to write the medical loss ratio

[1] Letter from Chairman Rockefeller to Commissioner Jane L. Cline, President, National Association of Insurance Commissioners (May 7, 2010) (online at: http://commerce.senate.gov/public/index.cfm?p=HearingsandPressReleases&ContentRecord_id=0ac42ce4-5b3c-4bc2-8f81-d5c98cffca95&ContentType_id=77eb43da-aa94-497d-a73f-5c951ff72372&Group_id=165806cd-d931-4605-aa86-7fafc5fd3536&MonthDisplay=5&YearDisplay=2010).

definitions in a way that will allow them to continue doing business as they did before the passage of health care reform.

The resources health insurance companies are throwing into their effort to weaken the medical loss ratio law appear almost limitless. Health insurance industry lobbyists, lawyers, and consultants pore over every word of NAIC draft proposals, monitor every teleconference, and swamp the NAIC working groups with comments and proposed revisions. By my count, the health insurance companies and their allies have now submitted almost 160 comment letters – totaling more than 600 pages – to the NAIC regarding implementation of the new medical loss ratio law. In contrast, representatives for the tens of millions of consumers and businesses who could potentially benefit from this law have submitted 23 comment letters.

As I wrote you in my May 7 letter, the purpose of the medical loss ratio provision was to make sure that most of consumers' health insurance premium dollars are going to pay for patient care, not for insurers' administrative costs and profits. As data collected and analyzed by the Senate Commerce Committee staff shows, many health insurance companies already operate with medical loss ratios that meet or exceed the new federally required minimums that go into effect on January 1, 2011; but many others do not.[2] These companies will have to decide whether they will continue with their current business model and pay rebates to their customers, or change their business practices to increase the portion of each premium dollar they spend on patient care.

While I recognize that implementing these new minimum loss ratios will create short-term challenges for some of the insurance carriers that NAIC members regulate, I respectfully request that you and your fellow Insurance Commissioners keep the consumers of your states foremost in your minds. As you continue to be deluged by letters, comments, and analyses from the insurance industry, I ask you to recall that the purpose of the new medical loss ratio law is to give the citizens and businesses of your states the health care coverage they pay for and deserve.

In this letter I will discuss the strategies health insurance companies have been employing to game the new minimum medical loss ratio law. The new law was intended to hold health insurance companies accountable for the way they use consumers' premium dollars. Health insurers' lobbying efforts have been focused on convincing the NAIC to adopt definitions that would allow them to escape this accountability and continue business as usual. With the exception of two issues I will discuss – fraud detection expenses and public disclosure – NAIC officials have so far wisely rejected these efforts and I urge you to continue doing so as the implementation process moves forward.

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[2] Senate Committee on Commerce, Science and Transportation, Office of Oversight and Investigations Majority Staff Report, *Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers* (Apr. 15, 2010) (online at: http://commerce.senate.gov/public/?a=Files.Serve&File_id=be0fd052-4ca6-4c12-9fb1-a5e4a09c0667).

The Health Insurance Industry Has Been Aggressively Lobbying the NAIC to Weaken the Definition of "Quality Improvement Expenses"

The Patient Protection and Affordable Care Act (PPACA) established for the first time federally required minimum medical loss ratios in the commercial health market. The new law sets the minimum medical loss ratios at 80% in the individual and small group markets, and 85% in the large group market. Insurers that fall below these levels are required to pay rebates to their policyholders.[3] While the standard method of calculating medical loss ratios in the insurance industry involves simply dividing an insurer's incurred claims by the value of premium dollars collected, the new law creates a new accounting category for expenditures on "activities that improve health care quality."[4] The new law allows health insurance companies to add their quality improvement expenditures to their incurred claims to calculate their medical loss ratios.

For example, if an insurer collects $100 million in premiums from business owners for small group coverage, and then uses $78 million of these premiums to pay claims and $22 million to pay administrative costs and profits (thereby operating at a 78% medical loss ratio), it would have to rebate $2 million to its policyholders. Under the new law, however, the insurer can meet the new law's 80% minimum loss ratio requirement, and thereby avoid paying rebates, if it can demonstrate that it spent $2 million of the premium dollars (2%) on "quality improvement expenses."

As I wrote to you in my May 7 letter, the purpose of this new category is to encourage health insurance companies to spend money on health care services that have been demonstrated to improve the safety, timeliness, and effectiveness of the care patients receive. In that letter, I urged you to carefully consider how you define "quality improvement expenses" during the implementation of this law, since health insurance companies have a strong financial incentive to reclassify as many administrative and business functions as possible as "quality-improving" expenditures in order to avoid paying rebates.

Over the past few months, the health insurance industry has behaved true to form. It has deluged the NAIC PPACA Actuarial Subgroup of the Accident and Health Working Group and the Health Reform Solvency Impact Subgroup of the Financial Condition (E) Committee with hundreds of pages of comments urging them to adopt a definition of quality improvement activities that would sweep in a whole host of operational and administrative expenses that have little or nothing to do with improving the quality of patient care. The effect of such a vague definition of quality improvement would be to allow insurers to meet the requirements of the new law without actually providing more or better care to their customers.

The Solvency Impact Subgroup wisely rejected the insurance industry's position that the term "Quality Improvement (QI) Expenses" should mean whatever the health insurance

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[3] Sec. 2718 of Title XXVII, Part A of the Public Health Service Act, as added by Sec. 10101(a) of Title X of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010).

[4] *Id.*, Sec. 2718(a)(2)

companies want it to mean. Instead, the Subgroup insisted that quality improvement expenses should actually "advance the delivery of patient-centered care," and should be "capable of being objectively measured."[5]

In hundreds of pages of comment letters, and in more than 20 hours of teleconferences, health insurance companies and their allies have lobbied the Solvency Impact Subgroup to weaken the principle that the "quality improvement" classification should be limited to expenses that have been proven – in an objective, verifiable way – to improve patient care. Instead, the industry would like the NAIC to believe that almost any expenditure health insurers make in the normal course of their business is intended to improve the quality of the care their policyholders receive. Some of the expenses insurers have claimed as quality improvements are the following:

- The money health insurance companies spend processing and paying claims;
- The money health insurance companies spend creating and maintaining their provider networks;
- The money health insurers spend updating their information technology systems to code medical conditions and process claims payments;
- The money health insurance companies spend to protect against fraud and other threats to the integrity of their payment systems; and
- The money health insurance companies use to conduct "utilization review" of paid claims to detect payments the companies deem inappropriate and retroactively deny them.

While these expenditures may promote cost containment or overall business efficiency and profitability, they do not directly improve the quality of care their patients receive and should not be shoehorned into the definition of quality improvement expenses. Accepting the industry's argument that almost any operational expenditure improves the quality of patients' care defeats the intent of the legislation to reward companies for focusing on services that have been demonstrated through evidence-based research to improve patient outcomes.[6]

For example, a number of insurers argued that the costs of running customer call centers staffed by health care professionals should be classified as "quality improvement expenses." But they offered very little evidence that the purpose of these call services is to improve the delivery

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[5] *See e.g.,* NAIC Health Reform Solvency Impact (E) Subgroup, *Draft Proposed Supplemental Health Care Exhibit to 2010 Annual Statement and Instructions for Life, Health, Property & Fraternal Insurers* (adopted by Subgroup on July 1, 2010) (adopted by NAIC Financial (E) Committee on July 7, 2010) (hereinafter "Currently Proposed MLR Exhibit") (online at: http://naic.org/documents/committees_e_hrsi_final_blanks_prop.pdf).

[6] According to a report released last week by two leading industry analysts, health insurance companies still have large potential savings in the administrative area: "Said differently, managed care plans have never demonstrated the ability to materially cut administrative spending. There's no question that these plans are very inefficient, and that there is the potential for big cost cuts, but we wouldn't forget that at its core, most plans in the industry are reliant on very old systems that limit how much productivity can be improved." Carl McDonald and James Naklicki, Citi Investment & Research Analysis, *Heads I Win, Tails You Lose: Initiating Coverage of the Diversified Managed Care Industry* (July 12, 2010).

of patient care rather than perform general administrative services, such as answering questions about coverage or billing. After lengthy discussions, the Solvency Impact Subgroup decided that these call center expenses should be considered administrative unless the insurer can demonstrate that the call centers provided actual quality improvement services that:

- Improve Health Outcomes;
- Prevent Hospital Readmissions;
- Improve Patient Safety and Reduce Medical Errors; or
- Promote Wellness and Health.[7]

For months, insurance industry representatives have been bitterly complaining to the NAIC that this "objective, verifiable results requirement" is overly narrow and restrictive. In a June 16, 2010 letter, for example, the Blue Cross Blue Shield Association (BCBSA) complained to the NAIC that requiring measurable and verifiable evidence that an expense improves the quality of care presented "unnecessary barriers and unreasonably high standards" for insurers.[8] BCBSA instead proposed a standard under which insurers could count as a quality improvement any expense that health insurance companies believed would "increase the likelihood" of better health outcomes.[9]

Figure 1 - UnitedHealthcare's June 28, 2010, Suggested Edit to the Definition of Quality Improvement Expenses

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 health services 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 which produce verifiable results and achievements~~.

Under standards such as this one, health insurance companies could claim that virtually any expenditure improves the quality of care their patients receive, and then have no obligation to prove their claims. In a June 28, 2010, letter to the NAIC, UnitedHealthcare made this point by suggesting an edit that literally crossed out the passage in the Subgroup's definition of quality

[7] These quality improvement goals mirror the goals listed in Section 2717 of PPACA ("Ensuring Quality of Care"), *supra*, note 3.

[8] Letter from Joan Gardner, Executive Director, State Services, Blue Cross Blue Shield Association to NAIC Health Reform Solvency Impact (E) Subgroup (June 16, 2010) (online at: http://www.naic.org/documents/committees_e_hrsi_100617_comment_bcbsa.pdf).

[9] *Id.*

improvement expenses that requires measurable, verifiable results (see Figure 1).[10] According to United and other health insurers, having to provide evidence to their customers and regulators that their expenditures are actually effective is an unreasonable burden.

Fraud Detection Expenses Should Not Be Considered Medical Expenses for the Purpose of Calculating the Medical Loss Ratio

In spite of health insurance companies' intense lobbying over the past few months, the Solvency Impact Subgroup charged with developing the new medical loss ratio reporting form (the "Blank") has appropriately rejected the industry's requests that they be allowed to classify a broad array of cost containment and administrative expenses as quality improvement expenses.[11] The instructions accompanying the proposed medical loss ratio reporting form list a number of expense items that are "broadly excluded" from the definition of quality improvement expenses. These are expenses that do not significantly contribute to improving health outcomes, preventing hospital re-admissions, reducing medical errors, or promoting health and wellness.

The one exception to this positive result is the Solvency Impact Subgroup's decision to allow health insurers to count some or all of their "fraud and abuse detection" expenditures as medical expenses for the purpose of calculating medical loss ratios.[12] While fraud detection is an important activity in both private and government-funded health care systems, its primary purpose is not to improve the quality of patient care. Health insurance companies should not be allowed to count their fraud expenditures towards satisfying the law's medical loss ratio requirements.

Identifying fraud and recovering fraudulently paid claims are undoubtedly valuable activities. Successful fraud prevention contains the overall cost of health care, and it identifies and removes bad actors from the health care system. But most of the fraudulent activity in our health care system involves billing and claim payments, rather than the medical treatment delivered to patients. According to the Federal Bureau of Investigation (FBI), the most prevalent forms of health care fraud involve providers who bill for health care never rendered, or who overcharge payers for medically necessary health care services.[13] While these types of fraudulent activities are a huge problem in our health care system, and cost Americans billions of

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[10] Letter from Thomas J. McGuire, Senior Deputy General Counsel, UnitedHealthcare to NAIC Health Reform Solvency Impact (E) Subgroup (June 28, 2010) (online at: http://www.naic.org/documents/committees_e_hrsi_100629_comments_united_healthcare.pdf).

[11] In my May 7 letter, I discussed the issue of cost containment expenses in more detail and presented data on how much money health insurance carriers spend on such expenses. *Supra*, note 1.

[12] Currently Proposed MLR Exhibit, *supra*, note 5, at 10. While the current Blank does not explicitly classify anti-fraud expenditures as quality improvement expenses, it allows carriers to "recognize" the expenses in the numerator of the medical loss ratio calculation, up to the amount of claims recovered as a result of the expenditure or the amount of anti-fraud expenses reported, whichever is less.

[13] Federal Bureau of Investigation, *Financial Crimes Report to the Public, Fiscal Year 2009* (online at http://www.fbi.gov/publications/financial/fcs_report2009/financial_crime_2009.htm).

dollars every year, they do not directly impact the quality of patient care, which is the focus of the new minimum medical loss ratio provision.

An additional problem created by this exception is that neither the reporting form nor its instructions provide a detailed definition of "fraud and abuse detection" expenses, which gives health insurance companies wide latitude to reclassify administrative expenses as fraud detection. For example, an insurance company could argue that the quintessentially administrative activity of reviewing consumer insurance applications for accuracy and completeness is actually an anti-fraud activity.

A recent example of a blatantly disingenuous health insurance industry "fraud and abuse detection" program was the practice of post-underwriting rescissions in the individual health insurance market. As was well documented by a series of reports and hearings by the House Energy & Commerce Committee, a number of health insurance companies denied claims and canceled policies of consumers who became sick and required expensive health care services.[14] While the companies' stated rationale for these post-underwriting reviews was to detect cases of fraud, it was clear from the evidence gathered in the Energy & Commerce investigation that the true purpose of these reviews was to avoid paying legitimate claims.[15] It would be truly ironic if a health insurance company could claim that money it spent to deny paying legitimate claims to its policyholders for needed medical care could be considered a "quality improvement expense."

The NAIC Should Not Protect Information about Health Insurance Companies' Quality Improvement Expenses from Public Disclosure

I strongly support the NAIC's Solvency Impact Subgroup's position that health insurance companies should have to produce objective, verifiable evidence that their expenditures are actually improving the quality of patient care before they can claim them as quality improvement expenses. I am disappointed, however, that the current NAIC draft form would prohibit the public release of the evidence insurers submit to substantiate their quality improvement expenses.

Under the reporting form instructions as they are currently drafted, health insurance companies would submit detailed descriptions of their quality expenses, including their expense

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[14] *See, e.g.,* U.S. House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Hearing on Terminations of Individual Health Policies by Insurance Companies*, 111th Cong. (June 16, 2009) (online at: http://energycommerce.house.gov/index.php?option=com_content&view=article&id=1671:energy-and-commerce-subcommittee-hearing-on-terminations-of-individual-health-policies-by-insurance-companies-&catid=133:subcommittee-on-oversight-and-investigations&Itemid=73).

[15] *Id.*, Testimony of Brian A. Sassi, President and CEO, Consumer Business, WellPoint, Inc. ("Rescission is one tool employed by WellPoint and other health insurers to protect the vast majority of policyholders who provide accurate and complete information from subsidizing the costs related to fraud and material representation. The bottom line is that rescission is about combating costs driven by fraud and misrepresentation.")

allocation methods, in a "separate, regulator only supplemental filing."[16] In other words, the NAIC would block consumers and independent researchers from obtaining important information about how health insurance companies are spending billions of consumers' premium dollars on purportedly quality-improving expenses.

While I acknowledge that health insurance companies have valid concerns about protecting their proprietary business information, I have to remind you that the health insurance industry has a track record of withholding valuable consumer information based on inappropriate business secrecy claims. When the Senate Commerce Committee began collecting information on health insurance industry medical loss ratios last year, many health insurance companies informed me that even basic information about how many premium dollars they spend on patient care versus administrative costs was "proprietary" and "business sensitive."[17]

In spite of the fact that the health insurance industry celebrates "transparency" and "consumer-driven" health care, I have found that the health insurance companies resist disclosing even basic financial information to consumers, providers, and outside experts. In an investigation the Commerce Committee conducted last year, for example, we found that health insurance companies failed to disclose to consumers and providers crucial information about how the companies calculated their out-of-network claims payments.[18] Consumers can take more responsibility for their health care decisions only if health insurance companies disclose the information consumers need to make informed, educated choices.

To address the health industry's refusal to share important policy and coverage information with American consumers, Congress included a number of new disclosure requirements in the new health reform legislation, including the medical loss ratio public reporting requirement in Section 2718 of the bill. The first paragraph of this section requires insurers to submit a "Clear Accounting of Costs" to the Secretary of Health and Human Services (HHS), and requires the HHS Secretary to make these costs readily available to the public. The preceding section of the law (Section 2717) establishes a separate quality of care reporting requirement for insurers. Protecting important consumer information behind a "regulator only" firewall is clearly not consistent with the spirit of laws such as these.

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[16] Currently Proposed MLR Exhibit, *supra*, note 5, at 18 and 23.

[17] *See* Letter from Chairman Rockefeller to Mr. H. Edward Hanway, Chairman and CEO of CIGNA (Nov. 2, 2009) (online at: http://commerce.senate.gov/public/index.cfm?p=HearingsandPressReleases&ContentRecord_id=dab514f7-1fc7-496b-a8b8-712987792fa8&ContentType_id=77eb43da-aa94-497d-a73f-5c951ff72372&Group_id=165806cd-d931-4605-aa86-7fafc5fd3536&MonthDisplay=11&YearDisplay=2009).

[18] *See, e.g.,* Senate Committee on Commerce, Science, and Transportation, Office of Oversight and Investigations Majority Staff Report, *Underpayments to Consumers by the Health Insurance Industry* (June 24, 2009) (online at: http://commerce.senate.gov/public/?a=Files.Serve&File_id=d930ee6d-24bf-4436-92ea-8a1d1bf1a5be).

Conclusion

I appreciate the hard work you and other NAIC members have been doing to implement the minimum medical loss ratio provision and many other parts of the new health care reform law. The health care reform law will continue to present us with both opportunities and challenges as the various provisions of the law phase in over the next few years. During this sometimes difficult process, I urge you to remember that our ultimate goal is decent, affordable health care for all American families. I look forward to continue working with you towards this goal.

Sincerely,

John D. Rockefeller IV
Chairman

cc: Kay Bailey Hutchison
Ranking Member

The Honorable Kathleen Sebelius
Secretary of Health and Human Services