



October 13, 2010

Commissioner Jane L. Cline, NAIC President
Commissioner Sandy Praeger, Chair of NAIC Health
and Managed Care (B) Committee
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

RE: AHIP Comments on the MLR Draft Regulation

Dear Commissioners Cline and Praeger:

As you prepare your final recommendations on the medical loss ratio (MLR) requirements and bring to fruition the months of hard work that you and your colleagues have devoted to this effort, we would like to offer several final thoughts for your consideration.

On the central question of whether the MLR regulation will advance the health reform goals of improving access to insurance, minimizing disruption for consumers and employers, and improving quality of care, we are concerned that the current draft proposal will create unintended consequences and not achieve the expected goals. We have appreciated the opportunity to participate in this important process and are committed to continuing to work with you. As you evaluate the comprehensive package of recommendations, we urge you to consider the need for a transition to prevent full scale market disruption across the country, the importance of ensuring that the proposed credibility adjustments work as expected, and the risk of potentially turning back the clock on quality improvement initiatives.

Your final decisions on these issues will have major implications for the success of MLR implementation and the broader health reform effort, and we appreciate your continued efforts to assess the implications of the draft proposals.

The Importance of Creating a Transition Strategy

The transition period between 2010 and 2014 will be especially critical to the success of health reform, and the NAIC is uniquely positioned – with its expertise and credibility – to take a leadership role in advancing a transition plan that meets the best interests of consumers.

The need for a transition strategy is related to the fact that most states currently have MLR standards that are based on “lifetime ratios” and are significantly lower than those established by PPACA. To address these issues, a transition plan that provides for an orderly progression to 2014 is essential. The consequence of not providing for an effective transition is a potential disruption of coverage for millions of Americans and reduced competition prior to implementation of the 2014 market reforms.

We have recommended that the MLR requirements be implemented through a phased-in approach that establishes a transition – based on a standard methodology established by NAIC – from current state requirements to the new PPACA standard. By establishing standard transition rules now, the NAIC can help promote stability of health plan choices in the individual and small group markets in the years leading up to the implementation of the 2014 market reforms. Failing to address this priority now will result in uncertainty and fewer choices for consumers.

To avoid this outcome, it is critically important for the NAIC to play a leadership role in developing standard transition rules that provide equal treatment to all similarly situated states, rather than making such decisions on a state-by-state basis without any consistency or predictability. With its expertise and unique collective knowledge of the insurance markets, the NAIC is strongly positioned to develop transition rules that will be effective in avoiding the displacement of coverage for consumers.

Ensuring That Credibility Adjustments Work

While the NAIC recognizes the need for credibility adjustments in its draft proposal, we are concerned that the current mechanisms will not work as intended. To promote access to a wide range of health plan choices for consumers and employers, the new MLR requirements should include adequate adjustments that take into account the statistical variability and credibility of small blocks of covered lives in an environment where extremely high cost, but low frequency claims (such as several complicated transplants or neonatology claims) can create major volatility.

To address these concerns, we urge you to modify the NAIC's existing credibility tables. The non-partisan American Academy of Actuaries has made this same recommendation and has cautioned that failing to take into account the needs of smaller blocks of business, as PPACA clearly instructs, will have the potential to damage markets and limit consumer choice. The Academy further notes that "the magnitude of credibility adjustments selected by the actuarial subgroup may not be sufficiently large enough to mitigate the risks faced by small blocks of business." The NAIC can address these serious concerns by strengthening the credibility adjuster to avoid potential insolvencies and support competition.

Not Turning Back the Clock on Quality Improvement

To ensure that individual patients receive the best care based on the latest available evidence, the NAIC's definition of "activities that improve health care quality" should be structured to ensure that current and future patients have access to the most up-to-date and innovative support programs and tools that health plans are able to develop.

Defining health care quality initiatives in a way that is too narrow or static will turn back the clock on progress and create new barriers to investment in the many activities that health plans have implemented to improve health care quality. To promote investments in quality improvement, we urge the NAIC to use the framework and criteria established by the Institute of Medicine (IOM) and the Agency for Healthcare Research and Quality (AHRQ), entities whose primary goal is to promote high quality health care for consumers. Both the IOM and AHRQ have long recognized that there are multiple components to health care quality and that the goal is to provide care that is safe, effective, patient-centered, timely, efficient, and equitable.

More specifically, we want to highlight our recommendations for modifying the definition of health care quality initiatives to include fraud prevention and detection programs and the initial startup costs associated with implementing the new ICD-10 coding system.

Fraud prevention and detection are key health care quality initiatives that help to enhance patient safety. Private health plans devote significant resources to anti-fraud programs, using a variety of tools to prevent, detect, and remedy fraudulent and abusive conduct, often in partnership with government agencies. These programs help to improve quality for the American people by identifying health care providers who are delivering care with false credentials, intentionally performing medically unnecessary procedures (e.g., surgeries), or falsifying medical records. They also address substance abuse related fraud, medical identity

theft, and other activities that have far-reaching implications for the quality of care received by patients. Because these investments play such a key role in improving patient care, they should be recognized by the MLR requirements as an important component of a broad-based strategy for improving health care quality.

Similarly, we strongly believe that the NAIC's definition of health care quality initiatives should include the startup costs that health plans incur in meeting the October 1, 2013 compliance deadline for ICD-10 implementation. The primary reason for the required adoption of the ICD-10 codes is to enhance the ability of the health care community to exchange and use detailed clinical data to deliver higher quality care to consumers. Implementation of ICD-10 will provide health plans and health care providers an expanded understanding of diagnoses and procedures at institutional settings of care, thereby enhancing the ability of providers and plans to categorize disease states, document medical complications, and track care outcomes. These advances, in turn, will support efforts to gain a deeper understanding of disease, causes of death, and ways to make significant improvements in health care quality. We strongly urge the NAIC to recognize that ICD-10 implementation is a major quality improvement initiative and not merely an administrative task surrounding the payment of claims.

We thank you for considering our recommendations for crafting MLR standards that support the goals of reform. We believe that the NAIC is uniquely positioned to ensure that the MLR requirements promote investments in quality initiatives and facilitate a smooth transition to the implementation of comprehensive health reform in 2014. Our members are strongly committed to working with the NAIC, state and federal officials, and other stakeholders to stabilize health care choices, enhance quality of care, and bolster the confidence of the American people as we move forward with the next stages of health reform.

Sincerely,



Karen Ignagni

c: Terri Vaughan, CEO, NAIC
Susan Voss, President-Elect, NAIC