May 14, 2010

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Attention: DHHS–2010–MLR
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: Consumer Watchdog Comments in Advance of Rulemaking for Section 2718 of the Public Health Service Act, Which Was Added by Sections 1001 and 10101 of the Patient Protection and Affordability Care Act (PPACA), Pub. L. 111-148.

Dear Secretary Sebelius,

Please accept this letter as Consumer Watchdog's response to the invitation by the Departments of Health and Human Services (HHS), Labor, and Treasury for public comments in advance of rulemaking.

In an attempt to make health insurers more efficient, section 2718, added to the Public Health Service Act by the recently enacted health reform law, requires that insurers spend at least 80 percent of customers' premiums on medical care in the individual insurance market, and 85 percent in the employer/group market. However, insurers have already begun gaming the new law in order to increase their profits by simply re-labeling administrative costs as "medical care." Without narrow regulatory definitions, broad transparency and stringent oversight, the law's efficiency goals will be lost.

The overarching goal of this rulemaking must be: Before any insurer reclassifies any function as "health quality improvement," the **insurer must provide credible scientific evidence that the function improves the health quality of individual policyholders.** This rule must apply not only prospectively, but also to any changes in the so-called "medical loss ratio" made during the year *before* passage of the Patient Protection Act, given recent wholesale reclassifications by WellPoint. Any program or function added under the new "health quality" definition must be stringently monitored by the states and the Department of Health and Human Services to protect against future abuses.

Specifically, section 2718 (b)(1)(A) requires health insurers to reimburse individual consumers and business owners if the ratio of "clinical services" and "activities to improve health care quality" to their "total premium revenue" falls below the required amounts. The Department of Health and Human Services bears the responsibility to ensure that the new regulations narrowly define "clinical services" and "health care quality activities" to block gaming of the medical loss ratio requirement.

Insurers must not be allowed to use tricks like the inclusion of the previously excluded Federal Employees Health Benefit Plan in calculating medical loss ratio, which would reduce the loss ratio without any increase in efficiency. The FEHB plans have long been excluded by the NAIC's own rules. They constitute a very large risk pool, and the government demands a highly efficient administration. They federal plans are not state-based, like other insurance. Most of the federal plans have medical loss ratios of over 90 percent. Their inclusion now would skew insurers' numbers upward, allowing them to meet the new law's 80 percent and 85 percent MLR requirements without creating any actual new efficiencies. The new law's minimum percentages did not envision this kind of statistical chess game, and HHS must reject it.

In fact, consumers will experience a negative benefit from this section of the law if insurers are allowed to include in the medical loss ratio their portion of business with the federal employee plan, anything they choose to designate as improving health quality, or even expenses they incur in collecting claims, as insurers including Blue Cross/Blue Shield are arguing. Insurers will so easily surpass the 80 and 85 percent minimums that they are likely to have *more* premium dollars to spend on remaining administration, executive salaries and profit, and the legal right to demand that policyholders pay the bill. Such wholesale reclassifications will thus put upward pressure on premiums.

Given the machinations evident in WellPoint's redefinition of what constitutes medical care, insurers must be required to publicly defend every item included in the medical loss ratio that is not a direct payment of claim or resulting change in reserves. Insurers must provide credible, independent clinical proof that the reclassified activities and functions are personalized for patients, and improve the health of individual insureds.

The rules must not allow administrative work to be defined as improving health quality if an activity or department has just a partial medical care role, or none at all. For instance, "utilization review" administrators are primarily in the business of cost-cutting, not in improving treatment. While broad cost reduction in medical care should be a goal of reform, the pressure on insurers to increase profit distorts the review function and negates any health quality role. Most consumers view utilization review as negative to their health quality. Marketing messages on websites or stuffed into consumers' monthly bills, with generic advice to lose weight or eat well, are not individualized health care. Monitoring programs aimed at detecting overbilling, upcoding and other fraud by physicians and hospitals are not health care. Contacts with doctor groups regarding contract details are not health care.

Some departments may contain a mix of health and administrative functions. For instance:

> **Nurse hotlines** may offer advice to individual policyholders, but also work with a stated goal of cost containment by preventing calls to doctors and visits to their offices. If the advice is overscripted, or not competent, such services may degrade rather than improve health care. Calls may be monitored by administrators to ensure that cost savings goals, such as time limits, are met. Hotlines may be in a department with patient schedulers and other clerical workers.
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> **Chronic disease programs.** Some may have a high level of individual support, others may not. Some diabetes programs and chronic heart disease supports have measurable benefits, others may not. Currently, there is no required measurement of such programs at the insurer level. HHS must require proof of *both* individualized care and health

performance *at the level of the individual insurer*. HHS or, where capability exists, the states, must conduct frequent, random audits of the efficacy of such programs.

Medical management, recently redefined as medical care by WellPoint, is a grab bag of undifferentiated functions. No such broad categories should be reclassified, period.

Other functions and departments that insurers may try to reclassify are clearly not health benefits. These include:

Utilization review. This is clearly an administrative function aimed at cutting costs, particularly by identifying expensive patients and restricting their treatment.

Claims settlement costs. This is unrelated to health improvement and often a result of denials of claims for doctor-recommended treatment.

Consumer Watchdog is also concerned with the role of the industry-funded National Association of Insurance Commissioners (NAIC) under section 2718 (c) to establish, *subject to certification of the Secretary of HHS*, these critical definitions. We are well aware that some state insurance commissioners take their consumer protection responsibilities seriously, and have done what they can to protect health care consumers from the kind of profit-padding that the new law seeks to address. The NAIC's consumer advisors' statement on MLR regulations is expert and focused on consumer protection. The committees working on PPACA regulatory recommendations have produced well-argued drafts.

The NAIC, however, is a private organization. It is not subject to the transparency and public participation rules of a government body, is funded in large part by the insurance industry, and NAIC officers enjoy a "revolving door" of job opportunities in the industry. It is the NAIC's board, not its committees or consumer advisors, that have the last word. The NAIC consumer advisory board's recommendations, and even committee recommendations, are frequently swept aside in final board decisions. The insurance industry's influence in the NAIC too often allows it to game the regulatory system through complicit regulators and loosely defined standards that industry actuaries are expert in manipulating. HHS must view the final NAIC recommendations through this prism.

Finally, section 2718 medical loss ratio requirements will—absent strict rate regulation—encourage insurers to raise their premium rates. In the same way that a Hollywood agent who gets a 20 percent cut of an actor's salary has an incentive to seek the highest salary, insurers will have incentive to increase health care costs and raise premiums so that their 15 percent or 20 percent cut is a larger dollar amount. However, section 2718, *in conjunction* with effective federal premium review and state regulation of rates under section 2794 of the Public Health Service Act that encourages state regulators to bar excessive rate increases, can ensure that insurance companies do not unnecessarily raise rates in order to boost profits.[1]

[1] See Consumer Watchdog's Forthcoming Comments in Advance of Rulemaking for Section 2794 of the Public Health Service Act, Which Was Added by Section 1003 of the Patient Protection and Affordability Care Act (PPACA), Pub. L. 111-148.

To that end, Consumer Watchdog makes the following specific comments:

1. The role and power of the industry-funded National Association of Insurance Commissioners. Section 2718 states that the NAIC "shall establish" the definitions and methodology for calculating the medical loss ratio. NAIC recommendations are subject to "certification" by the Secretary. Allowing the NAIC board to deliberate privately and deliver a completed package for up-or-down certification will not qualify as transparency, and will generate suspicions of undue industry influence.

2. Secretary's Certification of NAIC's "Uniform Definitions." Section 2718 (c) provides that the NAIC definitions will be "subject to the certification of the Secretary" of HHS. Consumer Watchdog acknowledges that the medical loss ratio is an imperfect measurement of efficiency and value. But it is measurable, and HHS must ensure that it is not measured to the specifications of the insurance industry or even the NAIC. HHS must not rubber-stamp whatever set of definitions are developed by the NAIC if those definitions fail to meet Congress's intent of making the health insurance industry more efficient. HHS must reserve the right to revise the NAIC recommendations, and to demand individual revisions as needed from the NAIC.

3. Question 1 (a) et seq. "What assumptions and methodologies do issuers use when calculating MLR-related statistics…?"

The advice of insurance companies ("issuers") must not be a deciding factor in establishing assumptions and methodologies for the following reasons:

- Consumer Watchdog has previously called on the Obama Administration and HHS to probe insurance giant WellPoint Inc. in light of a recent announcement to investors that WellPoint had already reclassified several functions from the administrative category to the "medical care" category in advance of the law's new minimum medical loss ratio requirements. It did so unilaterally and with the apparent intent to "grandfather" the rechristened functions as health care by revising several years of annual reporting.

  According to WellPoint's website: "Financial Information -- On January 1, 2010, WellPoint, Inc. began classifying certain benefits provided to improve its members' health and medical outcomes as benefit expense, as permitted by generally accepting accounting principles. These include costs for nurse hotlines, health and wellness programs, including disease management and medical management, and clinical health policy. Prior year amounts have been reclassified to conform to this new presentation." (http://phx.corporate-ir.net/phoenix.zhtml?c=130104&p=irol-financial_information).

  In particular, the addition of "medical management" is a grab bag that may include purely administrative units whose job is to deny as much expensive care as possible, and may include billing.

  The message to investors follows revelations that WellPoint, parent company of Anthem Blue Cross, also intentionally padded already huge premium increases in California, just in case regulators demanded reductions. Read more: http://www.consumerwatchdog.org/patients/articles/?storyId=33357.

Additionally, state regulators' review of Anthem Blue Cross rate increases of up to 39 percent in California found gross errors and overestimates of cost in the actuarial calculations used to determine the rate hikes. These errors and overestimates are unlikely to have been one-time occurrences.

- In a 16-page letter to the CEO of Cigna Insurance dated Nov. 2, 2009, Sen. Rockefeller outlines the bald deceptions of insurers (particularly Cigna) and their chief lobby, America's Health Insurance Plans (AHIP) in reporting differing medical loss ratio figures to investors, state regulators, Congress and the public. He also notes the refusal of the major for-profit insurers to voluntarily provide state-level medical loss ratio information, even though it could be mostly reconstructed from public reports delivered to the NAIC. Insurers have a vested interest in reporting low medical loss ratio figures to investors, and high medical loss ratio figures to regulators and the public. The differences in insurers' figures demonstrate the ease with which insurers manipulate medical loss ratio reports.

- Thus insurers' information and advice to regulators cannot be relied on, as is shown so clearly in the Rockefeller letter and its attached evidence.

4. Re Question B.3, **"What definitions currently exist for identifying and defining activities that improve health care quality?"** Again, the answers of insurers cannot be trusted, as shown by the hasty redefinitions of WellPoint administration as "medical care." In addition:

- No activity that is generic, such as insurer web sites or phone recordings providing "health news" or advising customers to lose weight and eat better, should be regarded as health care or improving health care quality. Such advice is derived from publicly financed research and is merely repackaged in what is also a marketing and customer-retention effort by the insurer.

- Activities that appear on the surface to offer personalized medical care must be thoroughly examined—for example, the insurer-staffed "nurse hotlines" recently reclassified by WellPoint. Such activities have the effect of keeping more revenue in-house for the insurer. They also may act as the opposite of a "medical home" by working from a script and discouraging regular contact with a familiar family physician or nurse practitioner. The "medical home," in which medical professionals oversee care at every level, is envisioned in the law as a key to better health and lower overall cost. The insurer advice hotline may actually work against the effectiveness of the medical home.

- Simply because a medical professional is employed in a department does not make it health care. The presence of one or more physicians and nurses in a utilization review department, signing letters and overseeing an administrative staff, does not qualify the department's activity as improving the health of insureds.

- Not all disease management programs are equal. As noted in a 2003 Health Affairs analysis, "Most payers implement [chronic disease management] programs only if they seem likely to reduce claim costs at least enough to offset program costs within a year. Common target populations include beneficiaries with asthma, diabetes, congestive heart

failure, and chronic obstructive pulmonary disease (COPD)."[2] While there is good research showing the benefits of individualized coaching and care, for instance in preventing diabetes-caused blindness and limb loss, there is no comprehensive literature comparing disease management provided by an insurer to management by a patient's medical provider. The Senate HELP committee bill would have encouraged insurers to pay efficient medical groups to provide disease management. The PPACA encourages insurers to provide it, by allowing them to shift the cost to MLR. Insurers must be required to provide independent, evidence-based and publicly available proof of the efficacy of their programs before HHS allows them to be reclassified as medical care.

5. Re Question C, **Levels of aggregation.** Consumers will receive the most accurate information and the greatest benefit from the smallest levels of aggregation of the medical loss ratio data. While very granular data may be confusing to individuals, it must be available to consumer groups and policy analysts in order to analyze compliance from a consumer perspective. At the very least, and in every state, information must be offered publicly by company, by state, and by group, small group and individual line of business. Insurers offering multiple individual and small group plans in a state should be required to make public the medical loss ratios of individual plans, no matter what level of aggregation is used for enforcement and rebate purposes.

We also urge the Secretary to be stringent and sparing in granting reductions to the 80% MLR minimum in the individual/small group market for the purpose of preserving competition, as provided for under section 2718(b)(1)(A)(ii). Insurers must not be allowed to get away with strategic threats to leave a market on the grounds that they cannot meet the 80-percent minimum MLR. The law already grants so much extra leeway that any insurer claiming inability to meet the minimum, unless the circumstances are exceptional (for instance an insurer *entering* a market, whose lack of older plans would skew its MLR downward) must be viewed with extreme skepticism.

Finally, any evidence provided by an insurer in defense of a reclassification, or in defense of a request of reduction of the minimum MLR, must be certified as true by the CEO of the insurer's parent company, under penalty of perjury—a sort of Sarbanes Oxley for insurance companies.

Thank you for your consideration of these key consumer issues, which may be otherwise drowned out by the sheer volume of insurer and regulator comments.

Sincerely,

Judy Dugan

Carmen Balber

Jerry Flanagan

cc: Jay Angoff, Director, Office of Consumer Information and Insurance Oversight, HSS
Donald B. Moulds, Acting Assistant Secretary Planning and Evaluation, HHS

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[2] Sandra Foote, Population-Based Disease Management Under Fee-For-Service Medicare, Health Affairs July 2003, *available at* http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.342v1/DC1