June 29, 2010

The Honorable Kathleen Sebelius
Secretary, Department of Health and Human Services
Hubert Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius,

The discovery that a second health insurer in California used "seriously flawed" calculations to justify individual policy rate increases averaging 19% is more evidence that given any amount of slack, insurers will undermine the first major market reforms to go into effect under the Patient Protection and Affordable Care Act (PPACA). The errors by Aetna, errors, whether inadvertent or deliberate, follow similar flaws found in an independent examination of Wellpoint's proposed 25% increases in California, causing both insurers to withdraw their increases.

The insurance industry is lobbying now for loopholes in regulatory language that would make it unnecessary for insurers to make mathematical "errors" in order to meet the law's requirement that they spend 80% to 85% of premium dollars on health care.

Regulations to implement the law's minimum 80% to 85% patient care ratio, also known as the "medical loss ratio," (MLR) are at serious risk. If insurers get away with bully tactics on this early implementation, the rest of the health reform law will be increasingly difficult to implement in ways that curb costs and protect consumers.

The most egregious example of interference is a June 4 letter[1] from the law firm representing United HealthCare to the National Association of Insurance Commissioners (NAIC). The letter, by the Washington firm of Alston and Bird LLP, implicitly threatens a legal assault on the new federal patient protections unless insurers are allowed to include whole categories of claims administration and legal costs as patient care.

Draft regulations regarding minimum spending on patient care (Section 2718 of the Patient Protection and Care Act, or PPACA) will be proposed to you by the NAIC, whose top officials have long had revolving-door employment relationships with the insurance industry. However, the final regulations will be up to you and your agency, and you must prevent any corporate end-run that weakens or destroys this early consumer protection.

[1] Letter from Alston and Bird LLP, representing United Healthcare, to Chairman Steve Ostlund of NAIC Accident and Health Working Group, June 4, 2010
http://www.naic.org/documents/committees_lhatf_ahwg_100614_united.pdf

The insurance industry's proposed redefinitions of "patient care," "administrative costs" and allowable tax exclusions from the calculation would pad the amount they appear to be spending on patient care by amounts that would not require any changes in their business model. They seek to remove any demand that would make the industry more efficient.

Insurance companies' efforts to pad their numbers fall into four broad categories:

Inclusion of broad administrative expenses in the patient care ratio. Insurers seek to include expenses in any way related to claims, such as review and denial of claims, legal costs of fighting claims, and settlements for wrongly denied claims, in the patient care ratio. Insurers currently list all such costs as administrative overhead.

Inclusion of specific but vaguely defined, primarily cost-cutting and often largely administrative programs as "health quality improvement" in the patient care ratio. Previously, for non-HMO plans, the medical loss ratio consisted only of claims paid to health professionals. The PPACA allows inclusion of insurer "health quality improvement" programs. Insurers seek to riddle this category with loopholes, for instance including insurer claims reviews, and information technology costs unrelated to health care--for instance billing programs and legal department IT.

Deduction of unrelated taxes from premium revenue. The PPACA allows for deduction of some federal and state taxes. Insurers seek to include federal income taxes as well as property, investment and other taxes unrelated to premium revenue. This would boost the MLR without requiring any effort by the insurer to become more efficient in handling administrative costs.

Exclusion of many individual insurance policies from 80% patient care spending requirement. The industry argues, without presenting evidence, that insurers will stop selling individual policies if not initially exempted from the 80% requirement. However, in most markets, and for virtually all large insurers, only newly issued policies would have ratios far below 80%, while older policies would (or should) have higher ratios. Since the MLR will be measured by an average of one company's individual plans in any state, threats of large-scale defections of insurers from the individual market should be regarded with extreme suspicion.

1. Administrative expenses

The June 4 letter from United HealthCare lawyers argues that any spending associated with a claim, a category known as "loss adjustment expense," or LAE, must be included as a patient-care expense. This category includes the dreaded "utilization review" departments that consumers see as existing primarily to delay and deny claims, as well as legal departments that fight claims payment, and the costs of settling unfairly denied claims.

The letter is largely couched in legal language, and includes an implicit threat to bring a lawsuit against the regulations in the District of Columbia federal court, widely regarded as the most corporate-friendly of the nine U.S. court districts.

While the legal argument is based on vagueness in the wording of the law, Section 2718 does clearly state that only "reimbursement for clinical services provided to enrollees under such coverage" and "activities that improve health care quality" may be counted in the medical loss ratio.

Most egregiously, the letter states that United HealthCare is concerned about "confusing" consumers. If insurers have to *report* their administrative claims expenses, but are not also allowed to define them as medical care, says the lawyer letter,

> "…consumers would be provided with information that has no relevance in respect to the MLR requirement… but would be merely a random piece of information that would simply serve to confuse consumers." *UHC letter, page 7*

Consumers are not simpletons. They are also concerned about results, not the arcana of process. And the result of insurers including all administrative claims handling as patient care, including salaries of administrative personnel and legal costs, would be to add about 5% to each medical loss ratio, according to annual statements by insurers that report these costs separately[2]. This is nearly enough by itself to moot the law's intent to make insurers more efficient and reduce overall health cost.

To its credit, the NAIC subcommittee considering regulatory language for Section 2718 has rejected demands for inclusion of all LAE expenses, including utilization review. But the subcommittee will not have the final word, even at the NAIC, and the industry will no doubt continue to lobby the NAIC board, which frequently changes committee and staff recommendations.

Insurers have argued separately that various smaller parts of loss administration expenses be redefined as "health quality improvements," including the vague category of "case management" and the fees insurers pay to rent provider networks and check their legal accreditation.

2. Health Quality Improvements

The PPACA explicitly allows insurers to include "health quality improvements" (HQI) in the medical loss ratio. This could conceivably include legitimate health quality improvement activities, such as patient-specific efforts to help individuals manage diabetes or chronic heart disease, with the aim of stabilizing the patient and preventing unnecessary hospitalization, or funding of a neighborhood clinic. However, insurers are already shifting internal definitions to include anything they currently consider "medical management," and other vague categories that are also part of the loss adjustment expenses discussed above.

For instance, Wellpoint unilaterally redefined its medical loss ratio for the last three years of financial reports to include undefined and formerly administrative departments. The changes were worth about a half-billion dollars annually and will likely raise the company's medical loss ratio by about 1.7%, according to a report by the staff of Sen. Rockefeller. In a message to investors in March, Wellpoint said disease management, medical management and a nurse hotline

> "are being reclassified [as part of the medical loss ratio] because they represent additional benefits provided to our members."

However, such departments are not new or additional, the names are vague and they have no standard definition. Their function may be more about denial of care than provision of care.

We urge HHS to certify NAIC's recommendations only when they present strict, clear definitions of any insurer-run "health quality improvements" that may be included in the so-called medical loss ratio. *Any such activity must produce independently measurable health improvements in individual patients,*

As you and your staff are aware, the committees and staff of the National Association of Insurance Commissioners (NAIC), which will recommend regulatory language to you, have resisted some of the most

[2] i.e. (Blue Cross) Horizon Healthcare of NJ, 2009, annual statement, page 4 worksheet: $106 million of listed LAE claim expenses equals 4.5% of $2.3 billion in claims cost.

vague and overbroad demands of the industry. However, insurers continue to send their own rewrites of proposed regulations directly to NAIC and will undoubtedly leverage the industry's close ties to the NAIC.

Terms such as case management, medical management and utilization review may overlap and do not hold uniform definitions—how they are used will vary between companies, and even within one company. Allowing even *one* vague term such as "wellness incentives" as an HQI will give insurers license to funnel administrative and marketing activities into the health improvement category.

Utilization review[3], an ambiguous category, is defined by the Maine Bureau of Insurance as a "program … meant to reduce unnecessary medical services."[4] However, the insurance industry's actual treatment denials are often arbitrary, capricious and explicitly aimed at maximum cost-cutting.

New York's Brookdale hospital, for instance, sued the HMO group HIP-NY and its associated utilization review company[5] in 2007 for collusion to deny legitimate hospitalization and treatment. The suit charged, among other things, that the HMO and its collusive partners, including some doctors:

- Used guidelines for one disease to disallow payment for treatment of a completely different disease, i.e. using infectious disease guidelines to deny treatment of a patient with brain cancer.

- Illegally permitted medically unqualified persons to make utilization determinations, with no regard for or reference to the medical facts of the case.

- Colluded with the HMO network's own "hospitalist" doctors to falsely note that patients were recommended for "discharge," even as the same hospitalist was ordering intensive tests or treatments. Thus multiple days of hospitalization were denied because of the trigger word "discharge" in the record.

- Refused to pay for patients admitted to the hospital through its emergency room, despite a contract with the HMO to provide emergency services to its members.

While dramatic, this example is similar to accusations that turn up repeatedly in other legal and enforcement actions and individual complaints.

Health information technology improvements are another large administrative loophole opportunity. Aetna, among other insurers, argues that all IT expenses that "directly and indirectly support quality" are health quality improvements. While some IT investments, such as well-crafted electronic health records used by doctors and hospitals, may lead to better health care quality for consumers, insurers' own IT investments largely serve business functions.

For instance Aetna, after experiencing declining revenues at the beginning of this decade, spent 20 million dollars on IT improvements known as the Executive Management Information System. The technology

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[3] Academy of Managed Care Pharmacy, Letter to Steve Ostlund, 5/13/2010. http://www.naic.org/documents/committees_e_hrsi_comments_0512exposure_AMCP.pdf

[4] State of Maine Bureau of Insurance, "Glossary of Insurance Terms", (http://www.maine.gov/pfr/insurance/glossary.htm)

[5] Brookdale University Hospital vs. Health Insurance Plan of New York and others, 2007, http://www.medisyshealth.org/documents/HIP-Cogent_Raceteering_Complaint.pdf

helped Aetna to "identify and dump unprofitable corporate accounts."[6] Aetna ultimately dropped 8 million—almost half—of their enrollees in order to reap record profits.[7]

Any inclusion of Health IT expenses in MLR should come with a clear and specific definition limiting it to only expenses that *directly* and *credibly* improve the quality of health care, and do not overlap, conflict with or fail to be compatible with similar health IT efforts by medical providers.

Blue Cross Blue Shield has also urged inclusion of "provider education," which is almost entirely related to billing and office management, aimed at getting doctors to conform to the insurer's procedures. Here are typical examples of "provider education" from Blue Cross Blue Shield websites of its provider education webinars:

- Billing, "part of our ongoing commitment to make it easier for you to do business with us."[8]
- Claims handling, to "streamline your administrative processes".[9]

To call such classes "health quality improvement" is ludicrous on its face.

3. Taxes on Property and Investment Income

As written, Section 2718 of the PPACA, allows "federal and state taxes and licensing or regulatory fees" to be deducted from premium revenue in its description of how the ratio of premiums collected and medical care provided will be calculated. The insurance industry, for example Wellpoint,[10] argues for the inclusion of every conceivable tax, from property taxes to taxes on investment income and capital gains, in this formula.

The relevant section of the law, however, is only about how to calculate the ratio of premiums collected to care provided. Thus taxes unrelated to premiums or provision of medical care should not be included, as they are irrelevant to the measurement of premiums in relation to health care.

Yet in a comment letter dated May 6, the lobbying group America's Health Insurance Plans (AHIP) argues:

> *All* "Federal and State taxes and licensing or regulatory fees" are to be deducted from the report on non-claims costs in Section 2718(a) (3), and from the rebate calculation in (b). There is no limitation that the taxes or fees must be "insurance" taxes. (emphasis added)

In the draft regulations under discussion[11] at the NAIC, inclusion of federal income tax as well as property taxes, presumably including real estate taxes on investment property, is being considered for deduction from premium revenue. The result of this sweeping tax inclusion would be to boost insurers' MLR by amounts varying from state to state without a single change in their business model.

It will be up to HHS to restrict this sweeping exclusion to taxes relevant to premiums collected.

4. Exceptions from 80% Minimum for Individual Health Policies

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[6] Barbara Martinez, Road to Recovery – Behind Aetna's Turnaround, *Wall Street Journal*, August 13, 2004.
[7] Ibid.
[8] http://www.bcbsm.com/provider/training_and_seminars/administrative_training_professional.shtml
[9] http://www.bcbsil.com/provider/training.htm
[10] WellPoint, Letter to Lou Felice, 5/17/10. http://www.naic.org/documents/committees_e_hrsi_comments_0512exposure_WLP.pdf
[11] NAIC Health Reform Blanks Proposal, June 15, 2010, Sections 1.5-1.7

America's Health Insurance Plans (AHIP) and Wellpoint, among others, assert that many companies in many states will need exceptions from the 80% MLR for their individual health insurance plans, under the clause of 2718 that allows the Secretary of HHS, in concert with state insurance commissioners, to reduce the minimum MLR in cases where it might cause market "disruption." AHIP threatens, without presenting evidence, that many insurers will leave the individual insurance market or cease issuing new plans if required to meet the 80% minimum MLR.

The NAIC subcommittee dealing with this issue seems conflicted and has said it intends only to send HHS a letter, not regulatory language, on this issue, recommending that some exceptions be allowed. Thus, the insurance industry lobbying on this issue will be aimed directly at HHS.

We urge you to define possible exceptions stringently and to require that decisions be made case by case—for instance, excepting a new individual policy type issued by a company newly entering a state market. No company with multiple individual plan types of varying durations in a state should be granted an exception.

In larger states, no exceptions at all should be contemplated for commercial health insurance companies with individual insurance lines. Even such companies may argue that the burden of broker fees makes it impossible to meet the 80% MLR in certain states. That is merely an argument for the restructuring of broker fees, reducing them and weighting them toward later policy years, which would also have the effect of supporting sustained customer service and better longevity of the policy.

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The health insurance industry, like the financial industry, cannot be allowed to regulate itself, for good reasons:

- A 2009 Congressional investigation of Wellpoint's policy rescissions found that the insurer gave employees "points" and financial rewards for canceling policies of individuals who fell seriously ill.
- The abovementioned independent actuarial review of premium increases by Blue Cross of California and Anthem this year found serious calculation errors in favor of the insurer.
- A Congressional investigation found that the Blue Cross rate hikes of up to 39% in California had also been padded by 5% to account for possible government demands that the increase be reduced.
- United Healthcare repeatedly sought to coerce employees, on company time and with company assistance, to lobby against key elements of health care reform.

These are not the actions of willing partners in reform.

Any ambiguity in the medical loss ratio regulations will be an invitation to health insurers to write their own definitions. With these early regulations, you and HHS can prove that someone is capable of saying "no" to health insurers, and meaning it.

Sincerely,

Judy Dugan Carmen Balber