



Copy of Emailed Comments
May 24, 2010

Dear Mr. Felice and Mr. Sells: The Alliance of Community Health Plans – whose members are non-profit health plans or health plans that are subsidiaries of non-profit systems – has previously commented on the NAIC draft Exhibit and Instructions for calculation of MLR in a letter submitted on May 10 and email dated May 14. We appreciate the time and effort that you and your colleagues continue to devote to this effort and the ongoing process of consultation with interested parties. We submit the following additional comments on the draft circulated on May 20. In case formatting gets lost in the email transmission, a copy of our comments is attached as a pdf.

Line 1.6 – State and Local Insurance Taxes and Assessments

We believe the last line in the instructions (on p. 7) which currently reads “State income taxes other than premium taxes” should be modified as follows:

State and local income, excise, and business taxes other than premium taxes.”

State and local jurisdictions may impose excise and business taxes on gross receipts from engaging in business activities within the jurisdiction, separate from income taxes.

Line 1.7 – State and Local Premium Taxes (Community Benefit Expenditures)

We urge reconsideration of the language in the instructions, which currently reads: “Payments for community based expenditures in lieu of premium tax but limited to the state premium tax rate.” (bottom of p. 7)

We appreciate that NAIC has recognized that community benefit expenditures should be subtracted from premium revenues in the denominator, akin to how federal and state taxes are deducted for for-profit insurers. These community benefit expenditures reflect federal requirements for tax-exempt health plans. Because this is an issue that uniquely affects tax-exempt plans, many of which are ACHP members, we are developing language that we hope to submit to you soon – but beyond noon CDT on May 24 – and we request your consideration of our language which we will submit as soon as possible. We would make two points at this time:

- First, while tax-exempt organizations are required to provide community benefits, there is not a one-to-one ratio to the amount of taxes that they would have paid if they were for-profit plans. Thus, we do not believe the following language in the instructions for Line 1.7 is correctly stated: “Payments for community based expenditures in lieu of premium tax but limited to the state premium tax rate.” All community benefit expenditures reported on the IRS Form 990 by tax-exempt organizations should be included as a subtraction in the denominator.
- Second, because community benefit expenditures derive from federal tax law, we believe that the subtraction for community benefit more properly belongs in the instructions for Line 1.5 rather than Line 1.7.

To reiterate, we will forward more specific language to you as soon as possible and request that you consider our recommended language in preparing the next draft.

Line 3 – Incurred Medical Incentive Pools and Bonuses

The instructions (bottom of p. 10) currently read: “Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to share savings or promote quality improvements as defined in the PPASA (section....)”

We appreciate your recognition of a point made in ACHP's earlier comments, that not all incentive bonuses involve shared savings arrangements. For example, many health plans provide quality bonuses to providers based on improvements in HEDIS scores. We believe the current language may still tie these payments to risk sharing arrangements and that the following language would be clearer:

Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to share savings or make incentive payments to providers to promote quality improvements as defined in the PPACA Section 2717.

Line 5 – Expenses for Health Care Quality Improvements

We know that NAIC continues to work on this difficult section. We offer the following comments for your consideration:

- At least two activities mentioned in PPACA Section 2717 are not included in the bulleted list of activities that improve quality and we believe they should be included as well: quality reporting and use of the medical homes model.
- The relationship between the bulleted activities and the four categories of activities is not clear. The draft uses the phrase “These activities are embedded in the following 4 categories...” but it would seem that it would be better to have one list of permitted activities rather than two.
- We continue to believe that the introductory paragraph for Line 5 sets a difficult threshold for quality activities. The phrase “in ways that can be objectively measured and verified” is both unnecessary to this paragraph and contradictory of the test in the last of the four categories of quality improvement activities. The phrase is unnecessary because this paragraph is simply introductory about the types of activities that improve the quality of care. And it is contradictory of the language in category 4 which requires an “adequate showing” and places on the proponent the burden of showing the Secretary that the costs improve quality. We agree that the burden should be on the proponent, just as the burden is on the entity submitting an annual statement to support *all* of the expenses listed in the statement. Entities listing quality-related expenses should be required to make a reasonable case that the activities improve quality, but “objectively measured and verified” seems to imply a scientific test that cannot yet be supported by the state of the art of health care quality improvement and could well inhibit innovative efforts to improve quality. Thus, our recommendation for the introductory paragraph would be:

Expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), that are designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care. ~~in ways that can be objectively measured and verified.~~

Alternately, we would suggest:

Expenses, other than those billed or allocated by a provider for care delivery (i.e. claims costs), that are designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care ~~in ways that can be objectively measured and verified.~~ The burden shall be on the proponent to show that these expenses improve the quality of health care.

- We have commented previously on the importance of accreditation, and encourage you to explicitly recognize in the list of activities that improve health care quality both the direct costs of seeking accreditation from a recognized accrediting agency as well as the costs of achieving the required standards.

Line 5.2 – HIT Expenses for Health Care Quality Improvements

The NCQA representative raised the question on last week's conference call about the non-IT costs of collecting and reporting on quality measures, especially the costly function of manual chart review and

patient surveys. ACHP agrees with this position, as we indicated in earlier comments submitted. It appeared from comments made by Mr. Felice and others that these expenses would be included on Line 5.2, but we recommend making this explicit, perhaps with the following addition to item #1 in these instructions:

1. Monitoring, measuring, or reporting clinical effectiveness, including chart review and other manual processes to derive information that is reported;

An alternate way of handling this might be to change the title of Line 5.2 to:

Data Collection and HIT Expenses for Health Care Quality Improvements

Thank you very much for your consideration of these recommendations. Please let me know if you have any questions or require additional information.

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